Statewide Universal Health Care Access Plans

Volume IV

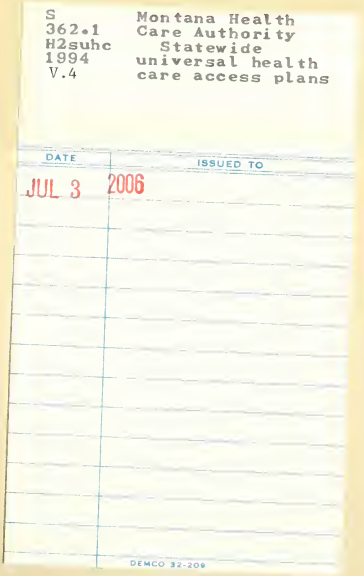
Public Participation Activities

State of Montana
Health Care Authority
Report to the Legislature
October 1, 1994

Statewide Universal Health Care Access Plans

Volume IV

Public Participation Activities



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INTRODUCTION

Volume IV of the *Statewide Universal Health Care Access Plans* is a compilation of reports detailing the public participation activities of the Montana Health Care Authority, including three Electronic Citizens' Forums, 10 Town Meetings, six public hearings on the Statewide Universal Health Care Access Plans, five public hearings on the Regional Health Care Resource Management Plans, a telephone survey of public attitudes on health care reform, and four issues of the Authority's health care reform newsletter.

The collection and compilation of public participation activities was completed and assembled by the Authority staff, with preliminary work completed through contracts with the following consultants: Elway Research on the Electronic Citizens' Forums, Dr. Joe Floyd and Ann Clancy on the Town Meetings, Dr. Joe Floyd on the Telephone Survey, the Regional Health Care Planning Board members and Civic Consulting on the Regional Health Care Resource Management Plans and Health Systems Research, Inc., on the Universal Access Plans.

MONTANA HEALTH CARE AUTHORITY

CITIZENS' ELECTRONIC FORUMS

Glasgow, Great Falls, Kalispell

JUNE 1994

ELWAY RESEARCH, INC.

2125 Fifth Avenue
Seattle, Washington 98121
(206) 728-1620

Introduction

This report presents the findings from a series of forums held to assess citizen understanding of, and concerns about, health care reform in Montana. The forums were sponsored by the Montana Health Care Authority and conducted by Elway Research, Inc. under contract with Civic Consulting.

Three forums were held in all, involving a total of 155 Montana residents. Participants were selected at random from the surrounding communities. The dates, locations and attendance for each forum were as follows:

May 16	Glasgow	38 citizens
May 18	Great Falls	63 citizens
May 19	Kalispell	54 citizens

Each of the forums was held in the evening between the hours of 6:30 pm and 9:30 pm.

Purpose

These forums were conceived and designed to allow the Montana Health Care Authority to explore in depth the thinking and opinions of everyday citizens across a wide range of topics related to health care reform. The forums also provided an opportunity to present information to citizens about the objectives and work of the Authority.

The forums were meant to involve citizens who might otherwise not be active participants in the health care reform discussion. There is no shortage of information and input from organized groups or citizens with strong viewpoints on particular issues involved with health care reform. Less vocal, and less active citizens are more difficult to hear from.

A key objective was to explore the issues in a comprehensive, systematic way. Health care reform is a complex topic, touching personal issues and broad public policy. The Authority sought to understand that complexity from the point of view of citizens. What elements do people consider to be pertinent to the issue of reform and pertinent to themselves? What connections do people make between elements? Answers to questions like these provide information which the Authority can use to develop not only health care reform packages, but also strategies to effectively communicate with Montanans about health care reform.

To achieve these objectives, the Authority wished to *engage* citizens at the forums, not just impart information or collect answers to questions. The forums were to be interactive, allowing the Authority and citizens to learn from each other.

Methods

Meeting Format

The Citizens' Forums were conducted using the Electronic Group Interaction System (EGIS), developed by Elway Research. EGIS is a portable computerized data collection and display system.

Participants were seated classroom style at long tables facing the front of the room. Each participant was given a handset connected to the EGIS computer. Questions were projected onto a screen and read aloud by a moderator. As each question was read, participants responded by means of their individual handset. Results were tabulated and immediately displayed to the group on the screen.

Participants responded anonymously, yet every participant saw the tabulated results of every question.

A total of 117 questions were administered. The protocol was identical for all three forums. A copy of the forum protocol is included in the appendix of this report.

Each of the three forums lasted approximately three hours. At two or three points in the meeting, a member of the Authority board, staff or consultant made a brief presentation about the issues, and the status of the Authority's work. There was an opportunity for public comment at the conclusion of each forum.

The electronic forum is a new technique for gathering citizen input. Although it bears resemblance to other modes, it is important to distinguish what these forums were not:

> They were not public hearings, at which representatives of organized interests stand in line at a podium to present their point of view;
>
> They were not sample surveys, where citizens are called or mailed one at a time and privately respond to questions;
>
> They were certainly not votes, where the results carry specific implications for action.

The Electronic Forums let sponsors and participants alike see how participants answer a wide variety of questions. They were designed to enhance learning, by indicating areas of agreement, disagreement and confusion. Participants were not asked for conclusions. Instead, the protocol was designed to have participants indicate how much they liked or disliked various concepts. "Black and white" forced choice questions were generally avoided. Most questions were scale items, which allowed participants to indicate differences of degree as well as direction.

The interspersion of presentations by representatives of the Authority allowed for information to be focused and targeted to areas of citizen misunderstanding.

Selection of Participants

In keeping with the purpose of exploring the thinking of typical Montana citizens, participants in the electronic forums were selected at random and invited to participate.

The three sites chosen represent an urban, a rural and a frontier community, as well a geographic dispersion.

Sample selection was based upon random digit dialing within telephone prefixes surrounding each forum site. Random digit dialing guarantees the inclusion of non-listed telephone numbers in the sample frame.

Professional interviewers from Eastern Montana College placed the calls, explaining the general purpose of the forum and inviting the citizen to participate. Those who agreed received a letter from Dorothy Bradley, chair of the Authority, further explaining the forum and reinforcing the importance of their participation. The night before the forum, each person received a reminder telephone call.

The participation rates for the three forums were as follows:

SITE	INVITED	PARTICIPANTS (%)
Glasgow	125	38 (30%)
Great Falls	175	63 (36%)
Kalispell	150	54 (36%)
TOTAL	450	155 (34%)

These participation rates compare favorably with other methods of data collection, such as mail surveys and even some telephone surveys, where much less is asked of participants.

Because these were open public meetings, other citizens, not part of the selected sample, also attended the Forums. They were seated in a separate section. These citizens took part in the open discussions at the conclusion of each forum, but did not have a handset and thus did not participate in the interactive polling.

A demographic profile of the random sample participants appears in the following section of this report.

Protocol Development

The protocol used in the Electronic Forums was designed by Elway Research in close cooperation with the staff of the Montana Health Care Authority. Several drafts were passed back and forth between Elway Research, Authority staff, and other consultants before the final version was completed.

One advantage of EGIS is that it allows a great number of questions to be asked, tabulated and displayed in a relatively short amount of time. The protocol used in these forums included 117 questions, which allowed for a comprehensive exploration of citizen thinking about a number of related issues.

Summary of Results

This section provides a brief summary of major findings from the interactive polling portion of the citizen forums. Following this section is a complete set of charts displaying results to all the questions and tables displaying the results for each of the three forums.

Most of these forum participants favored some level of health care system reform. Perhaps owing to the widely held opinion that insurance companies were the most influential players in the health care system, the most popular reforms had to do with health care insurance, as opposed to health care per se.

Major components of health care reform now under consideration both in Montana and nationally, met with mixed response.

Support for health *insurance* reform is also consistent with the mixed willingness to pay for health care *system* reform.

Eight in 10 Said System Needs Change

Some 78% of these participants indicated that the health care system in Montana was in need of change. This includes 18% who thought the system needed a "fundamental overhaul" and 26% said "major reform." Only 5% said no change was needed.

Reducing Cost Seen as Major Goal of Reform

Asked to rate the importance of eight potential goals of reform, a majority of participants rated each one as important. For five of the eight goals, a majority rated it "very important," the highest point on the rating scale.

When asked to choose one from the list as "the single most important" goal of health care reform, nearly half (48%) chose either "stopping cost increases" (25%) or "reducing waste" in the system (23%). "Emphasizing preventive care," which had rated the highest when the goals were considered individually (72% "very important"), was a distant third (9%) when the goals were ranked against each other.

Public-Private Partnership Should Manage Change

When asked who would best manage the "changes needed in health care system," 41% said a combination of government and the health care industry. The industry alone was the choice of 32% of participants, while government alone was selected by only 9%.

Insurance Companies Seen as Most Influential

Nearly half of the participants (48%) said insurance companies had the "most influence" over how the present health care system is run. Physicians (14%) and the Federal Government (13%) were well behind in second and third positions.

Hospitals Seen as Leading Cost Driver

Participants rated hospital charges highest of 15 factors in terms of how much each one "contributes to the cost of health care." Two-thirds of all participants rated hospital charges at 8 or above on a 10-point scale. Three other factors had majorities above 8 on the scale:

Malpractice suits (56%);
Insurance companies (54%);
Administrative costs (50%).

Most Reform Concepts Popular

Most participants liked most of the major objectives of health care reform. Participants were asked whether they generally liked or disliked 12 concepts related to health care reform. A majority liked seven of the 12.

Two of the three most popular ideas had to do with security of coverage. The top three were:

Preventing cancellation of health care coverage (75% liked that idea);
Limiting insurance premium increases (73%);
Eliminating pre-existing conditions restrictions (70%).

The least popular ideas had to do with employee participation. Only one majority appeared on the "dislike" side of the scale: 57% registered dislike of an employer mandate to cover all employees. A plurality (41%) also disliked the idea that employers would have to pay most of the health care premium for their employees.

Mixed Reviews for Reform Components

Five "building blocks" of health care reform were presented individually for participant evaluation. These were:

Purchasing Cooperatives:
Integrated Health Service Networks;
Global Budgeting;
Core Benefits;
Medical Savings Account.

Results were mixed: Only two were liked by a majority of participants, but only one was disliked by a majority.

The medical savings account and the concept of core benefits were most popular: four times as many participants liked those concepts as disliked them. Global budgeting was least popular: by a margin of 6:1, more participants said they disliked than liked that concept.

20 of 27 "Core Benefits" Favored

Participants rated some 27 medical treatments and services in terms of whether they should be included as part of the "core benefits provided to everyone in Montana." The scale was "definitely yes" (+5) to "definitely not" (-5). Twenty of the 27 had average scores on the positive side of the scale.

It should be noted that there may have been confusion about the definition of "core benefits." Feedback from participants indicated that at least some respondents may have been rating these services in terms of whether they should be *available* to Montanans, not whether they should be part of a heath care reform package. For this reason, results from this segment should be interpreted with caution.

The results do indicate what services participants thought were important. Those with the highest proportion saying they should "definitely" be included were:

Preventive care (62%);
Emergency care (61%);
Surgery (55%);
Laboratory/Diagnostics services (54%);
Abortion when necessary to save mother (54%).

Those with the highest proportion saying they should "definitely not" be included were:

Abortion (59%);
Contraceptive services (49%);
Acupuncture (44%);
Family Planning services (42%);
Substance abuse treatment (36%).

Personal Impacts of Health Care Reform

An important part of how people view any proposed change is how they think their personal situation will be changed in the new order.

Forum participants were presented six common concerns about health care reform and asked how each would change: first under health care reform as they understood it; and second if the health care system were not reformed.

In general, participants in these forums tended to anticipate their costs going up under reform, while they believed the quality of their health care would go down. Under the status quo, participants generally anticipated tax and cost increases, but little change in other aspects of their health care.

The table below summarizes the anticipated impacts of health care reform, and the status quo.

ANTICIPATED IMPACTS

WITH REFORM		NO REFORM	
INCREASE	*DECREASE*	*INCREASE*	*NO CHANGE*
Taxes	Choice	Taxes	Security
Cost	Benefits	Cost	Quality
Security	Quality		Benefits
			Choice

Nine in 10 participants thought their taxes would go up under health care reform, and 58% thought their health care costs would rise. Without reform, 68% thought their health care costs would go up and 54% thought their taxes would rise.

Mixed Willingness to "Pay"

Participants were asked how willing they would be to change their behavior or pay "in order to extend health care coverage to more people and contain health care costs."

There was willingness to change on behalf of these goals. Most were willing to:

> make co-payments for visits; and prescriptions (65%),
> wait longer for appointments with their provider (59%), and
> make fewer non-emergency visits to their provider (53%).

As usual, choice was the main obstacle:

> Two-thirds were unwilling to limit their choice of doctors.

Participants were more evenly divided (although there were unwilling pluralities) on accepting limitations on choice of plans, and on limiting access to medical technology.

Six participants in 10 were willing to pay higher health insurance premiums "in order to extend health care coverage to more people and contain health care costs." This included 21% who were willing to pay $10 per month more.

One-third of these participants were unwilling to pay anything more on their monthly health insurance premium.

Some 40% said they would use the same amount of medical services if their deductible were increased. Even more, 69% said they would use the same amount of services if their co-payments were increased $5 to $10.

No Existing Plan Has Significant Support

Not one of the five major plans put to these forum participants came close to majority support. This despite widespread opinion that rather significant changes are needed in the health care system; and despite strong support for several of the goals of health care reform; and despite support for many of the components that comprise the major reform packages under consideration in Congress.

Participants were asked to rate each on a scale of "very appealing" (+5) to "very unappealing" (-5). All five had pluralities on the "not appealing" side of the scale.

The Clinton Plan registered the highest level of appeal (34%) but even it was rated unappealing by a 4:3 margin. The Single (Government) Payer plan was least appealing to forum participants: 55% rated it unappealing, while only 6% found it appealing.

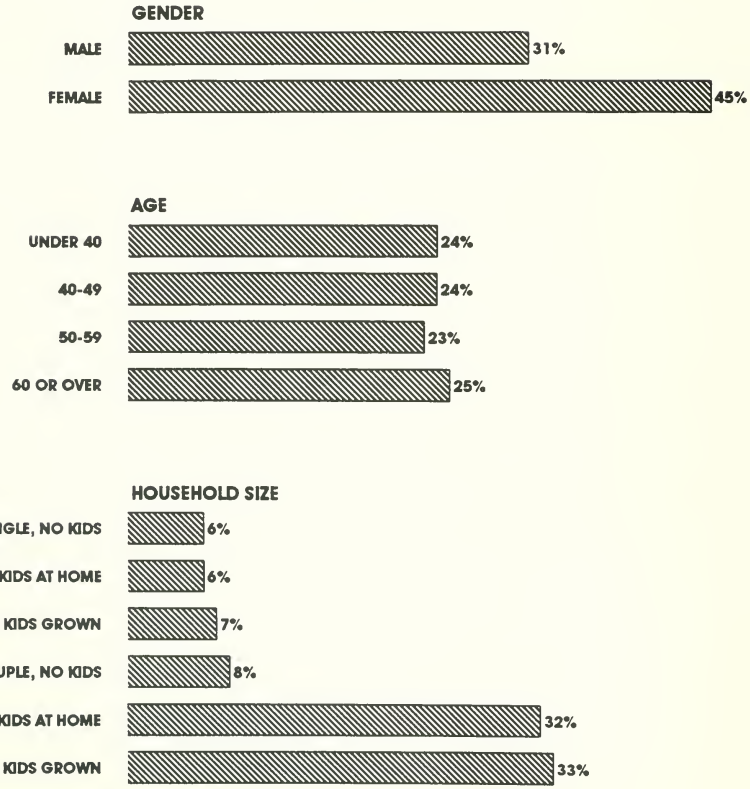
The On-Going Discussion: A Way to Go Yet

The last question of the interactive polling segment of each forum was how well participants understood the health care reform process in Montana "at this time." The scale was "very well" (+5) to "not at all" (-5).

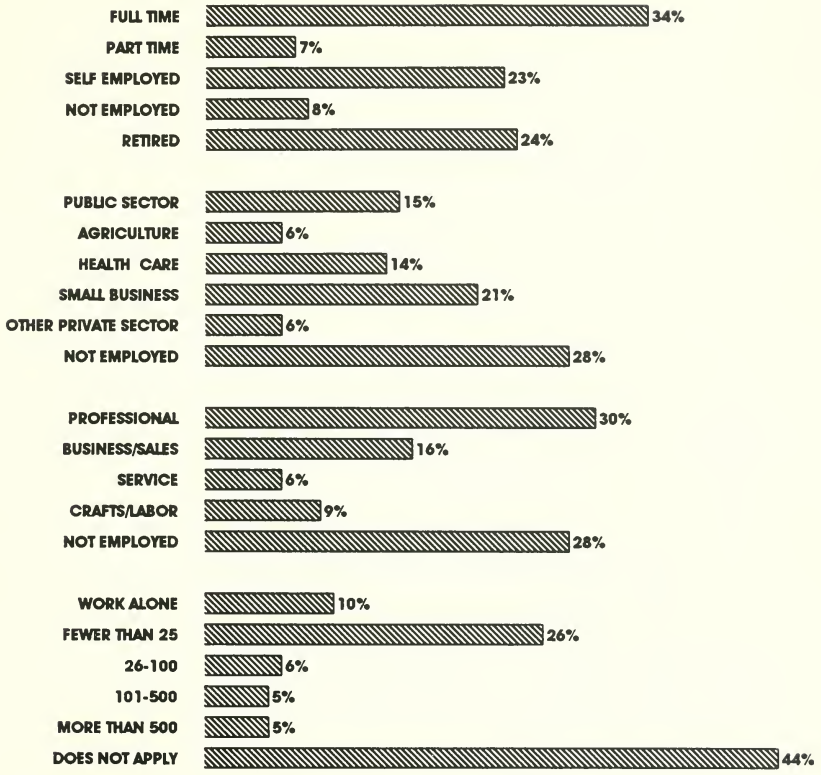
Nearly half (48%) placed themselves on the negative side of the scale, including 27% who scored -3 to -5. Some 37% thought they understood the process at least somewhat.

CHARTS
WITH QUESTIONS GROUPED

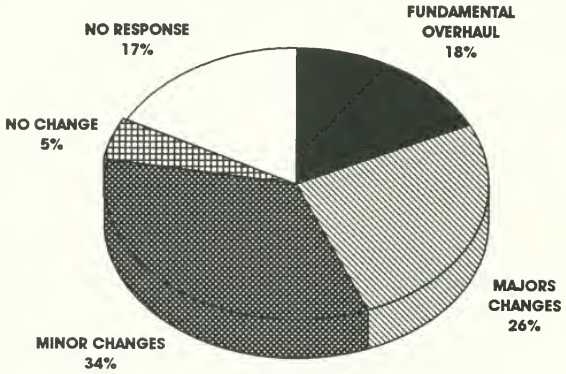
SAMPLE PROFILE



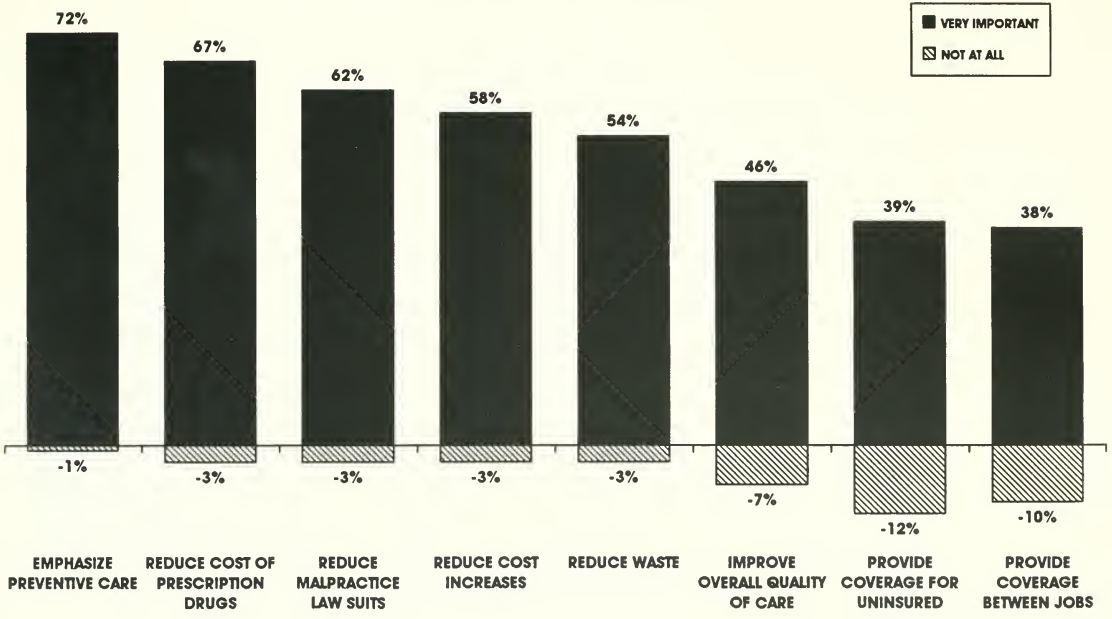
EMPLOYMENT


FULL TIME 34%
PART TIME 7%
SELF EMPLOYED 23%
NOT EMPLOYED 8%
RETIRED 24%
PUBLIC SECTOR 15%
AGRICULTURE 6%
HEALTH CARE 14%
SMALL BUSINESS 21%
OTHER PRIVATE SECTOR 6%
NOT EMPLOYED 28%
PROFESSIONAL 30%
BUSINESS/SALES 16%
SERVICE 6%
CRAFTS/LABOR 9%
NOT EMPLOYED 28%
WORK ALONE 10%
FEWER THAN 25 26%
26-100 6%
101-500 5%
MORE THAN 500 5%
DOES NOT APPLY 44%

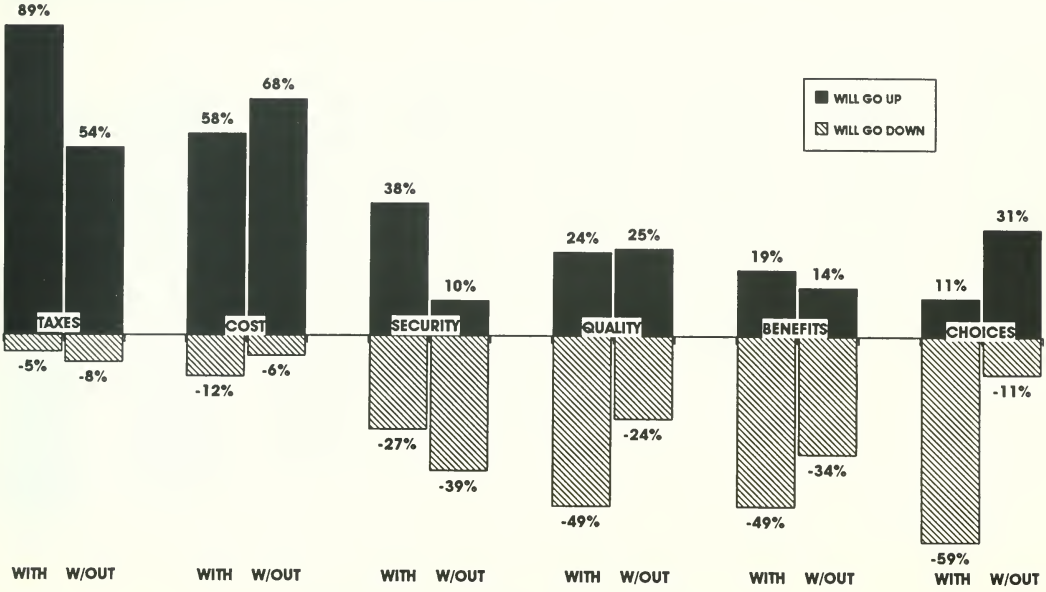
CHANGE NEEDED IN MONTANA HEALTH CARE SYSTEM



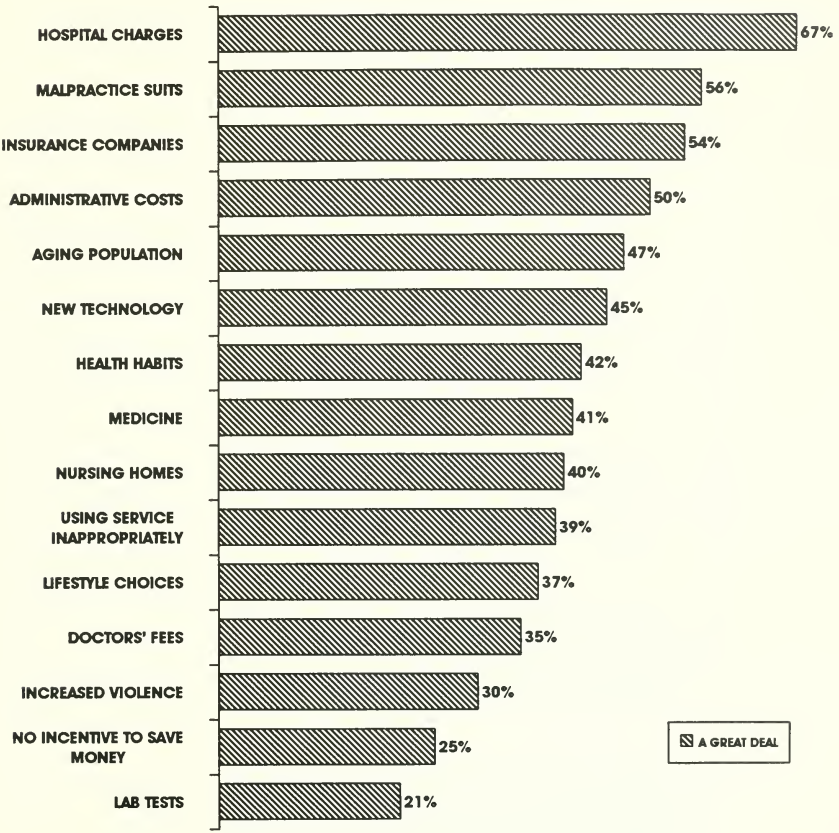
RATING GOALS OF HEALTH CARE REFORM



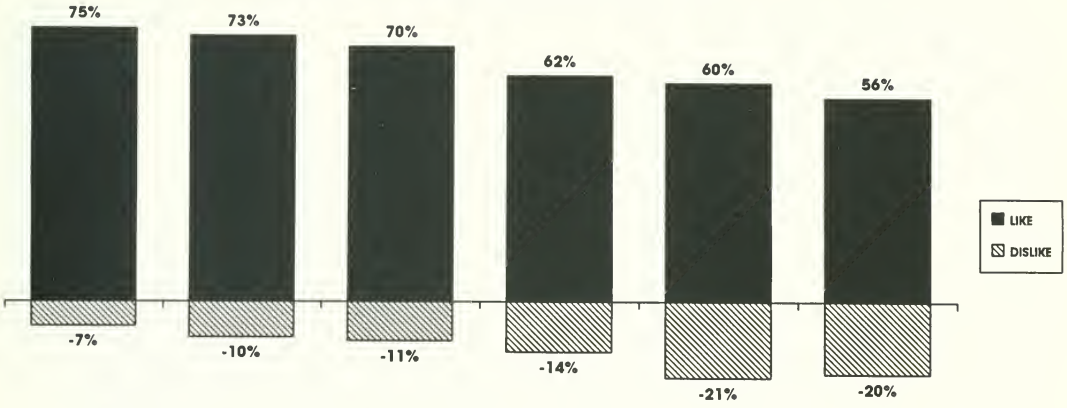
ANTICIPATED IMPACTS OF HEALTH CARE REFORM



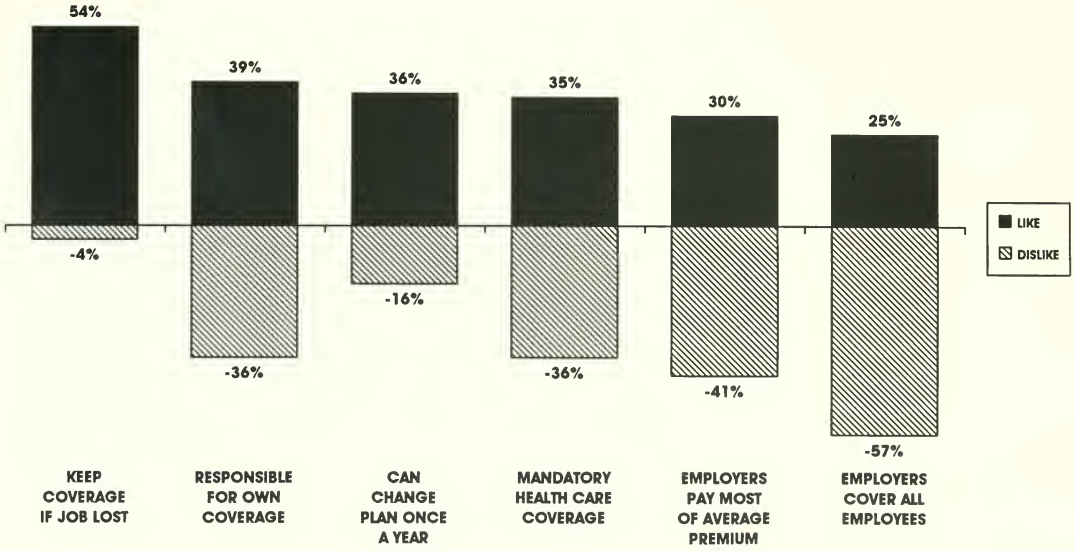
HEALTH CARE COST DRIVERS



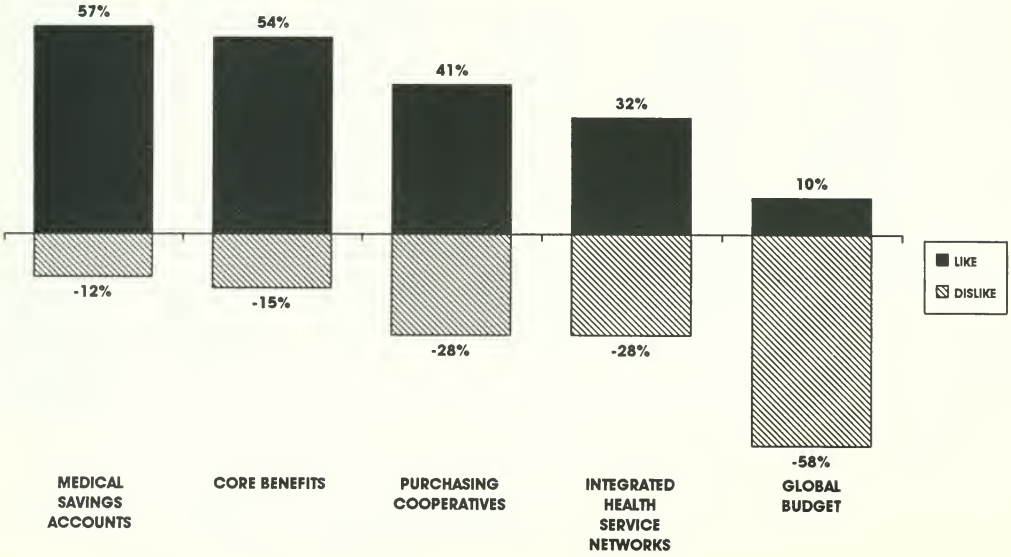
HEALTH CARE REFORM CONCEPTS, Part 1 of 2



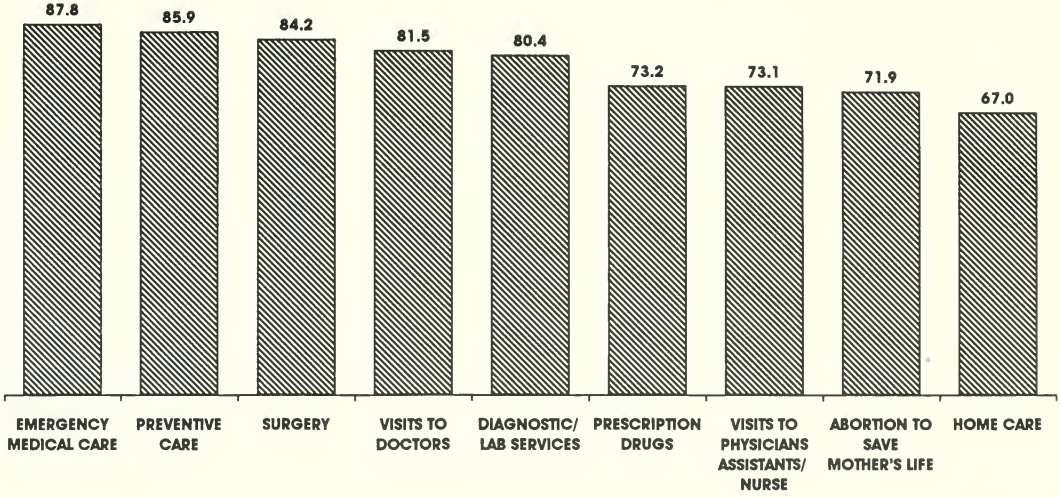
HEALTH CARE REFORM CONCEPTS, Part 2 of 2



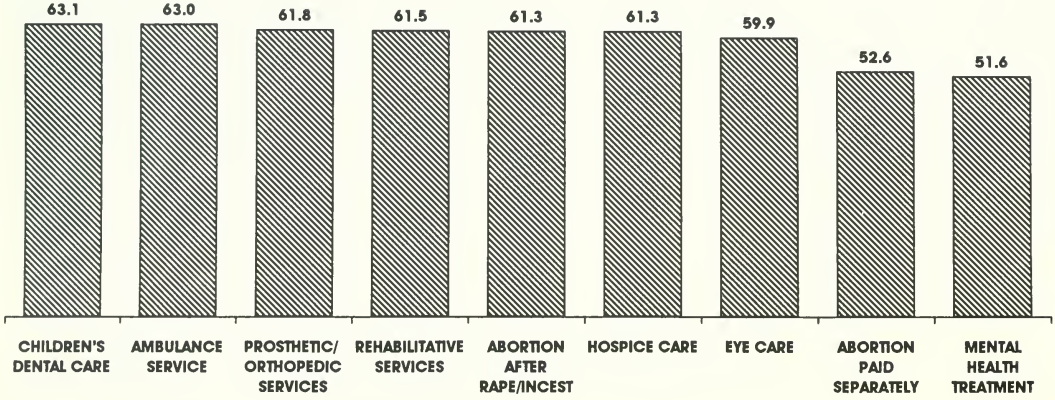
HEALTH CARE REFORM COMPONENTS



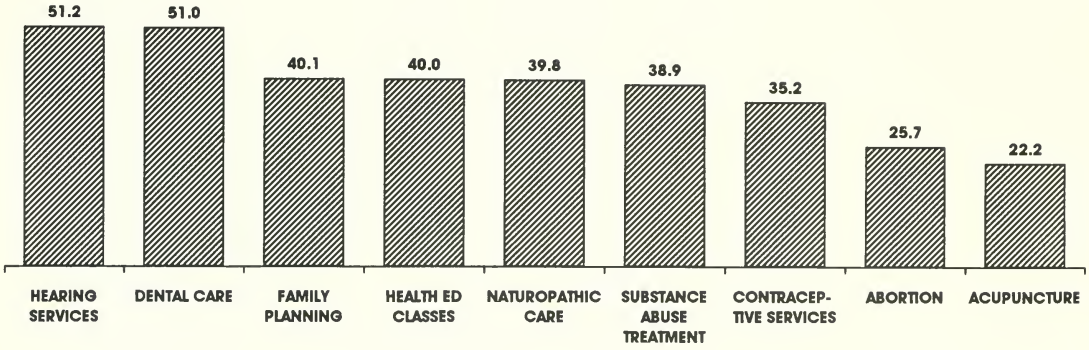
CORE HEALTH INSURANCE BENEFITS, Part 1 of 3
(Average score, 100=Definitely Yes)



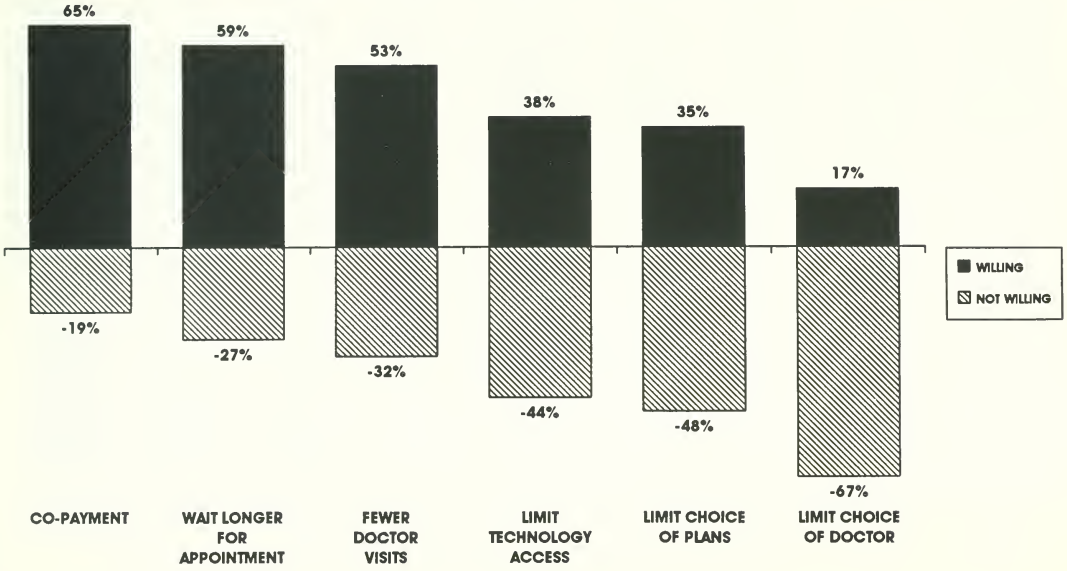
CORE HEALTH INSURANCE BENEFITS, Part 2 of 3



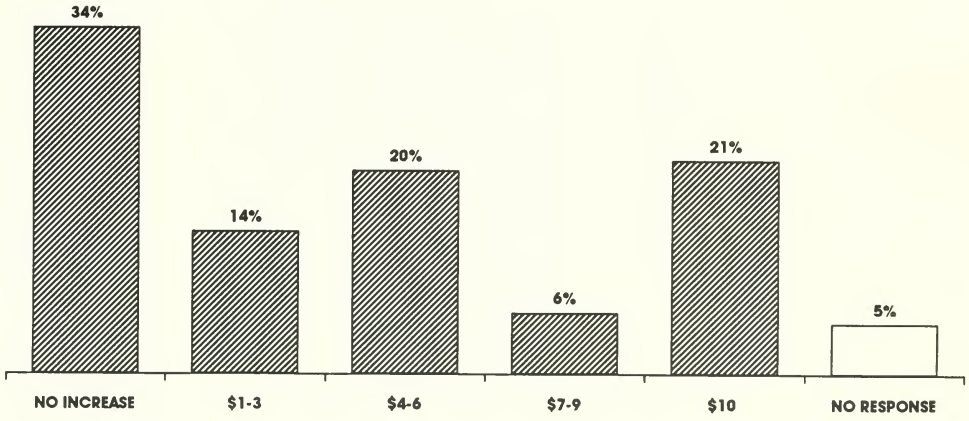
CORE HEALTH INSURANCE BENEFITS, Part 3 of 3



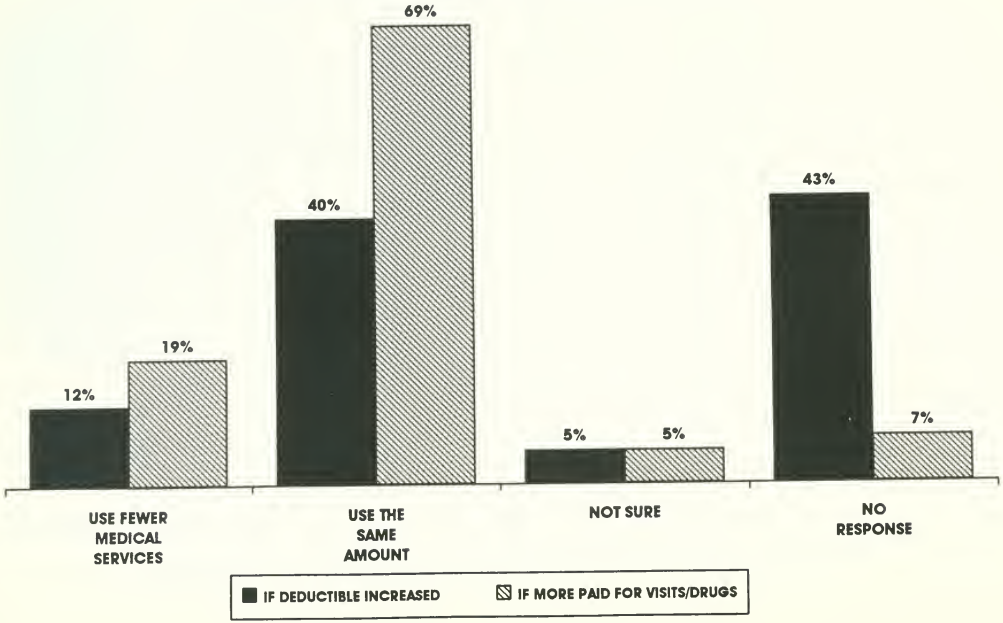
WILLING TO "PAY" TO EXTEND COVERAGE & CONTAIN COST



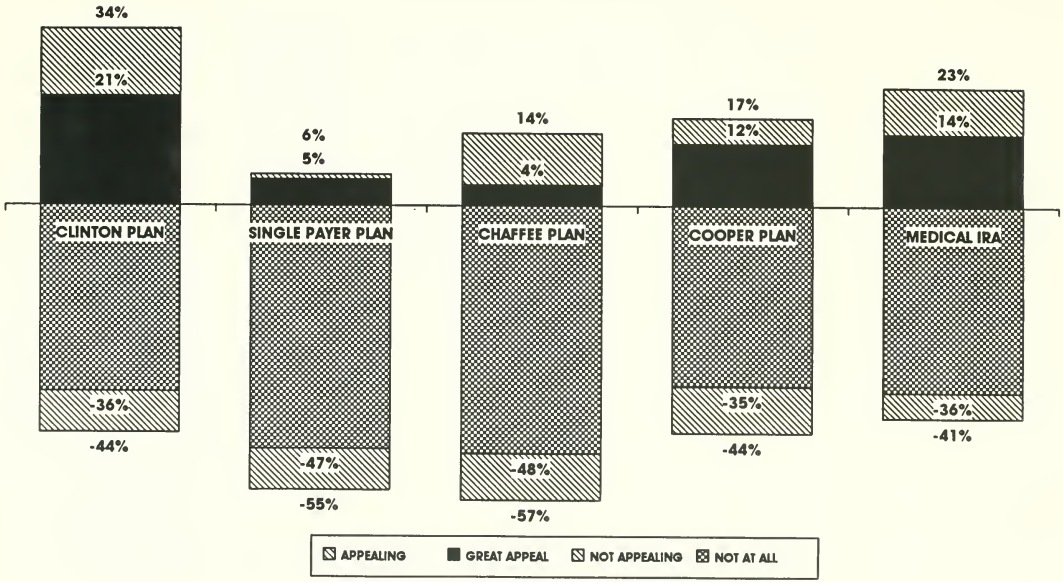
WILLING TO PAY PREMIUM INCREASE FOR EXTENDED COVERAGE



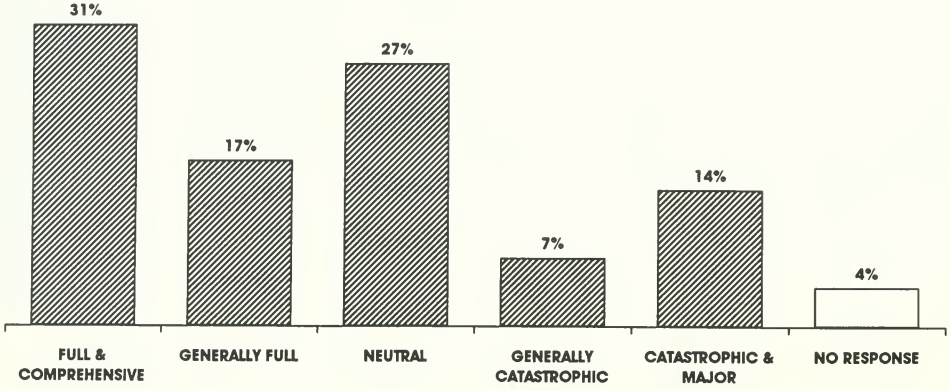
EFFECT OF CHANGES ON MEDICAL SERVICE USE



PROPOSED HEALTH CARE PLANS



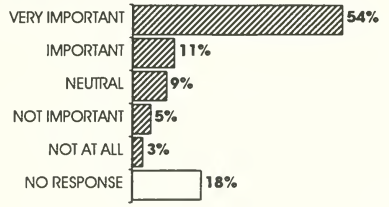
PRIMARY PURPOSE OF HEALTH INSURANCE COVERAGE



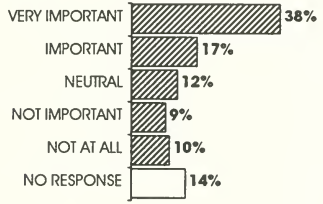
CHARTS OF INDIVIDUAL QUESTIONS

RATE THE FOLLOWING AS GOALS OF HEALTH CARE REFORM

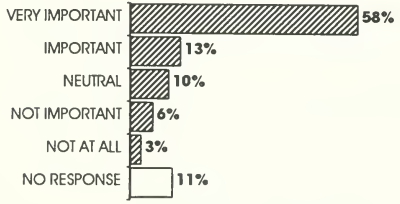
Reduce waste/inefficiency



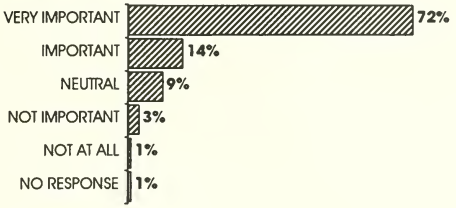
Provide coverage between jobs



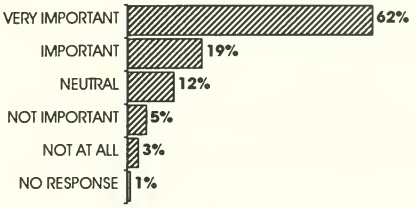
Reduce cost increases



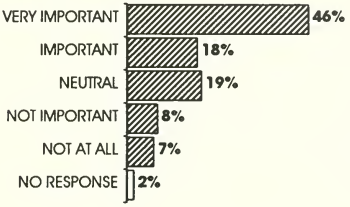
Emphasize preventive care



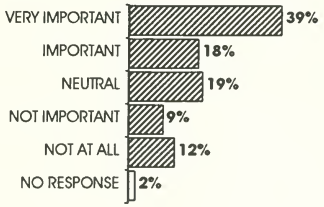
Reduce malpractice suits



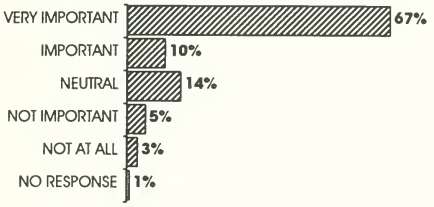
Improve overall health care quality



Provide coverage for uninsured



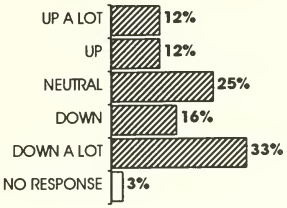
Reduce drug costs



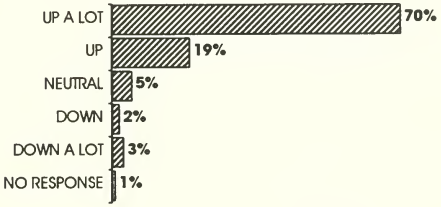
IMPACTS OF HEALTH CARE REFORM

Under health care reform...

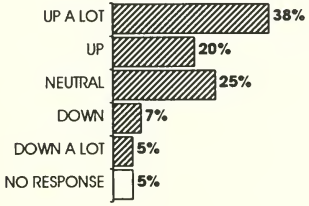
The Quality of my health care will go...



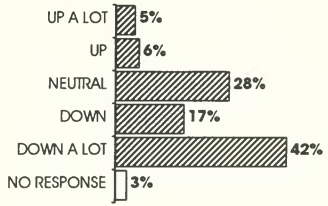
My Taxes will go...



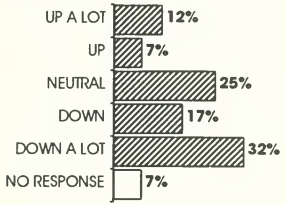
My health care Costs will go...



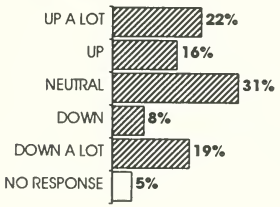
My Choice of provider will go...



My health care Benefits will go...

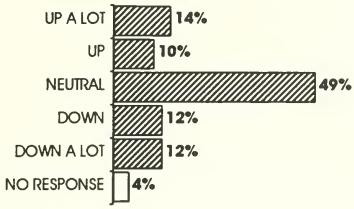


The Security of my coverage will go...

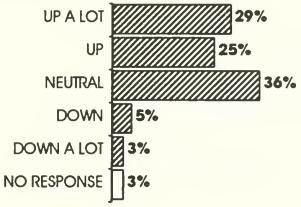


If the health care system stays the same...

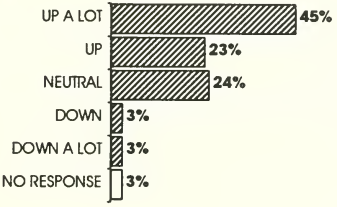
The Quality of my health care will go...



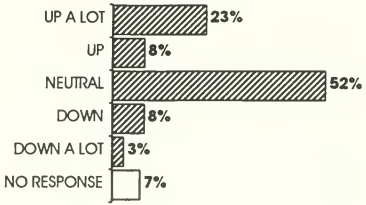
My Taxes will go...



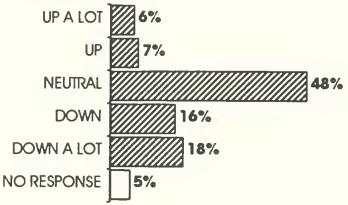
My health care Costs will go...



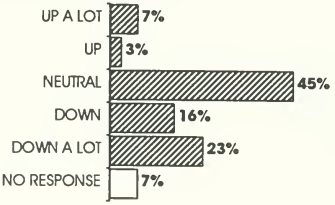
My Choice of provider will go...



My health care Benefits will go...



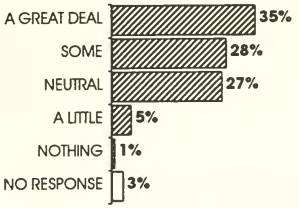
The Security of my coverage will go...



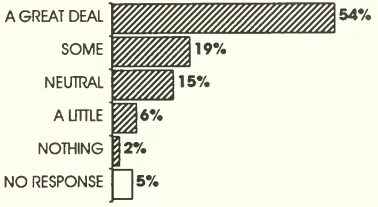
HEALTH CARE COST

How much do each of the following contribute to the cost of health care

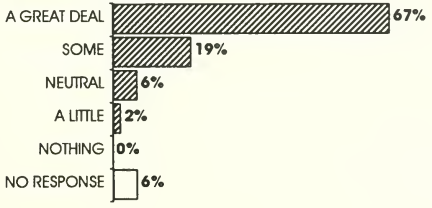
Doctors' fees



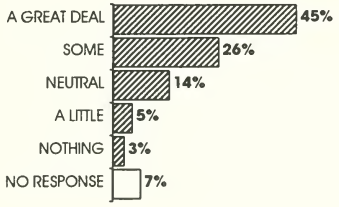
Insurance companies



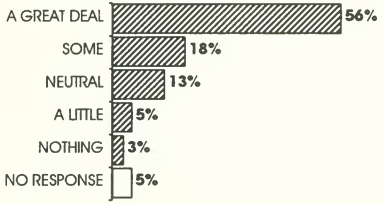
Hospital charges, excluding doctor fees



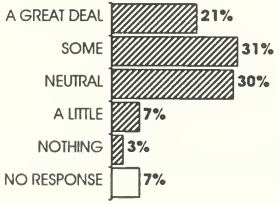
New technology



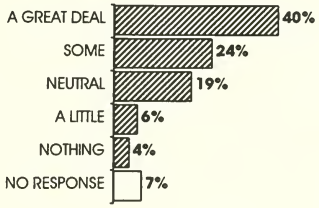
Malpractice law suits



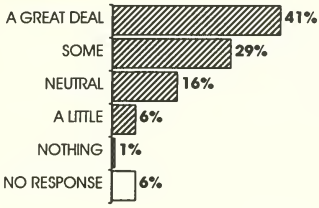
Lab tests



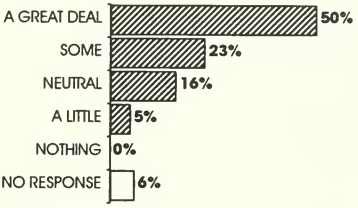
Nursing homes & long term care



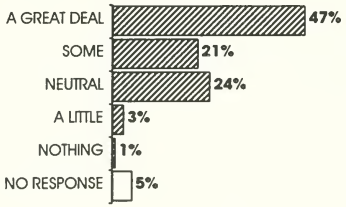
Medicine/pharmaceuticals



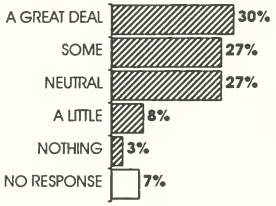
Administrative costs



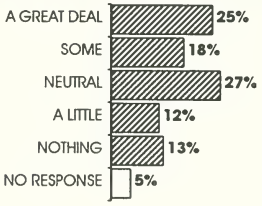
Taking care of an aging population



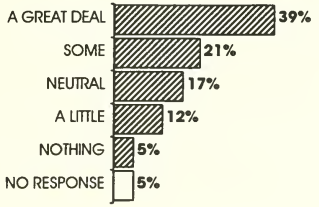
Increased violence in society



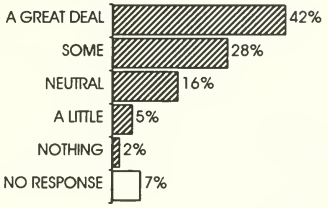
Lack of incentive for consumers to save money



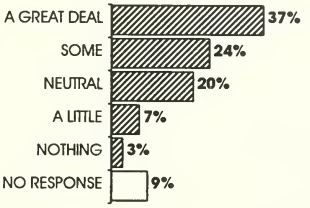
Consumers using health care services inappropriately



Health habits of individuals



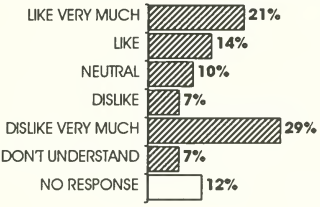
Lifestyle choices of individuals



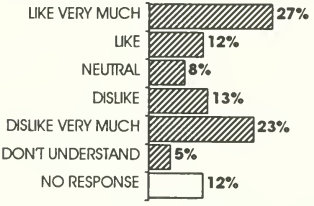
HEALTH CARE REFORM CONCEPTS

Evaluate the following ideas about health care reform

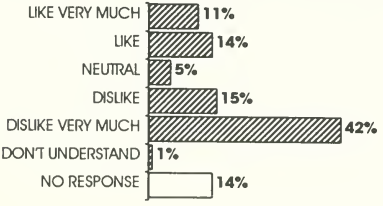
Require all Montanans to have health care coverage



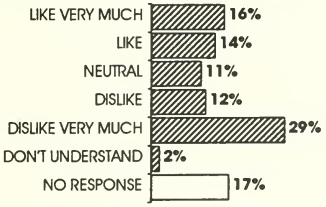
Require all Montanans to be responsible for his/her own coverage



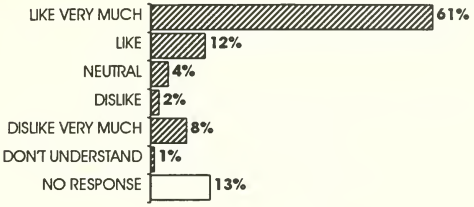
Require all employers be responsible for health care coverage for all employees



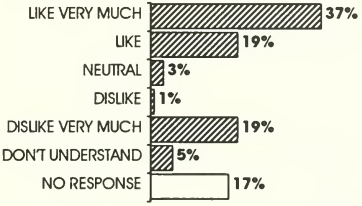
Require employees to pay most of the average priced premium in the state



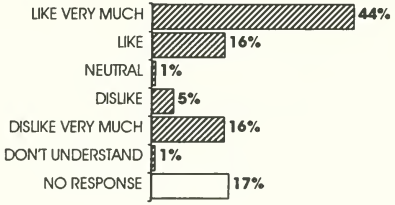
Place a limit on the dollar amount that insurance premiums can increase each year



Regulate the fees charged by doctors and other providers

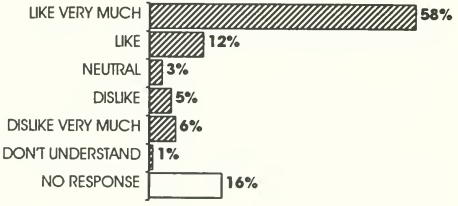


Regulate the fees charged by hospitals

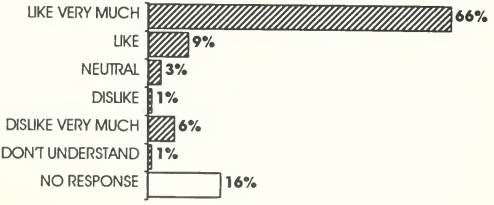


Are the following proposals a good idea or a bad idea.

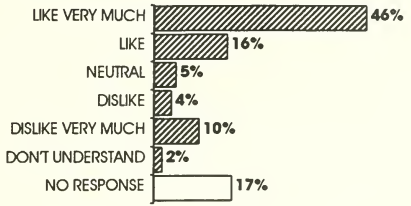
No one could be denied health care coverage because of "pre-existing conditions"



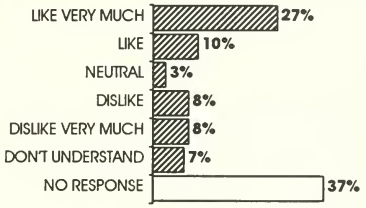
No one could have their health care coverage cancelled for any reason (except failure to pay)



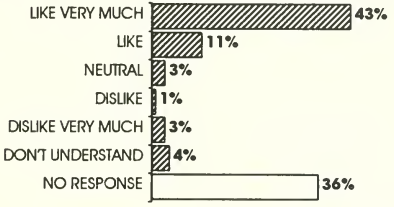
Employees could choose their own health care plans from among all plans offered, instead of from a list supplied by their employer



Employees could keep their same coverage if they lost their job or changed jobs



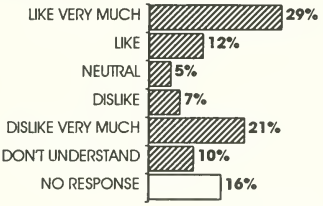
Everyone would have the opportunity to change health care plans once a year



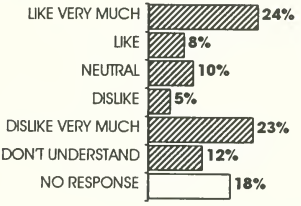
HEALTH CARE REFORM COMPONENTS

The following are major components of health care reform plans now being discussed. For each one, indicate how it sounds to you.

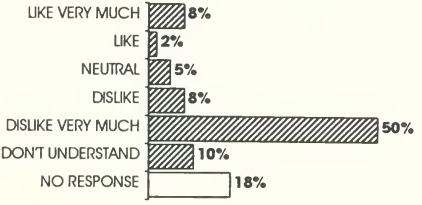
Purchasing cooperatives



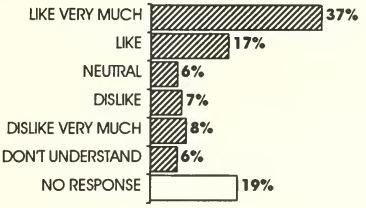
Integrated health service networks



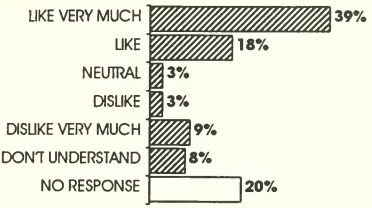
Global budget



Core benefits



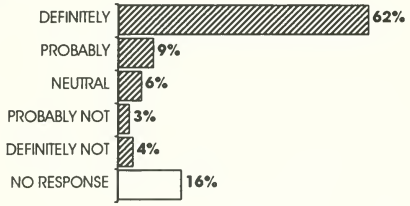
Medical savings account



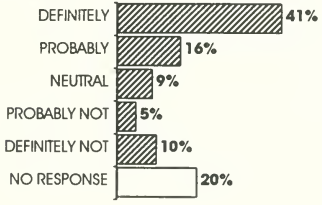
CORE HEALTH INSURANCE BENEFITS

Should the following be included in the "Core Benefits" provided to everyone in Montana?

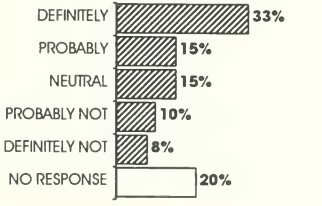
Preventive care



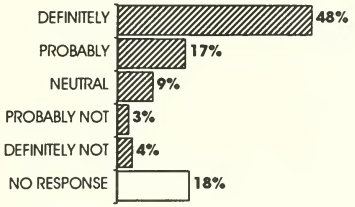
Prescription drugs



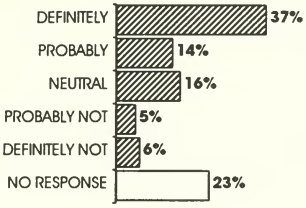
Home care



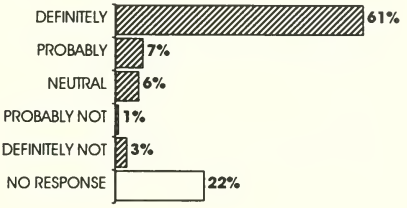
Visits to doctors



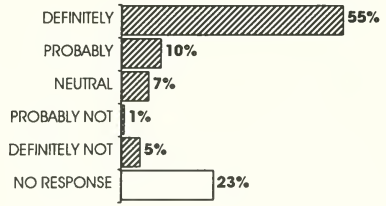
Visits to physician assistants & nurse practitioners



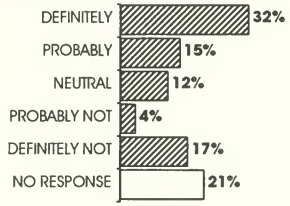
Emergency medical care



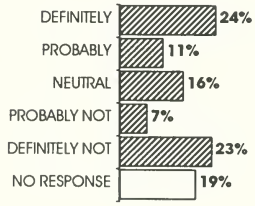
Surgery



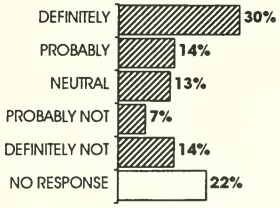
Ambulance service



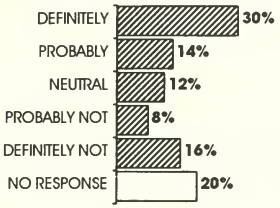
Dental care



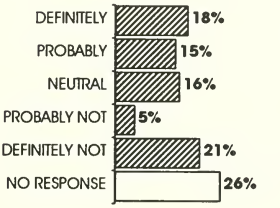
Children's dental care



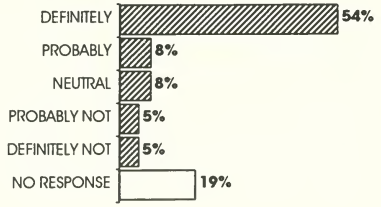
Eye or vision care



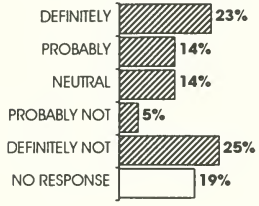
Hearing services



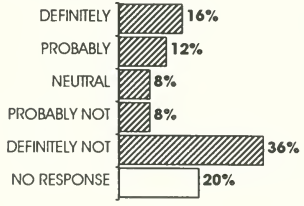
Laboratory/diagnostic services



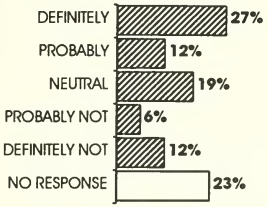
Mental health treatment



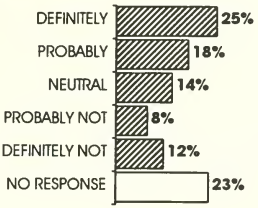
Substance abuse treatment



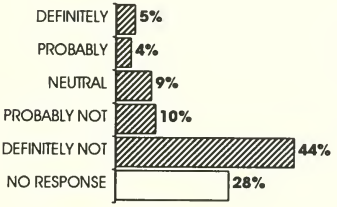
Prosthetic or orthopedic services



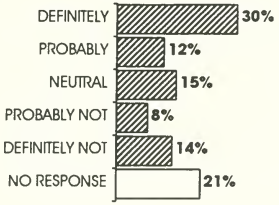
Rehabilitative services



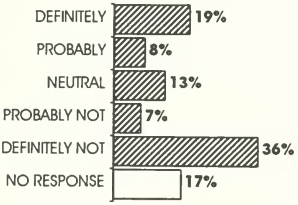
Acupuncture



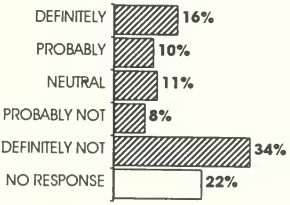
Hospice care



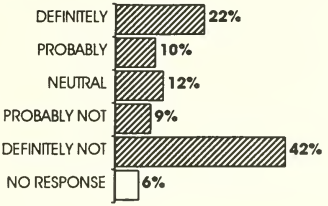
Health education classes



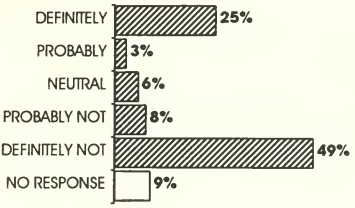
Naturopathic care



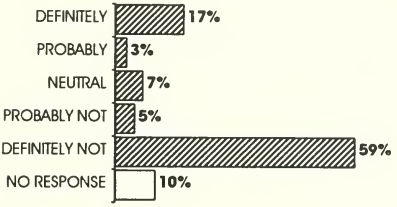
Family planning education



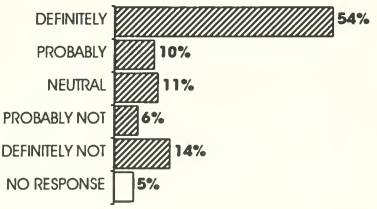
Contraceptive services



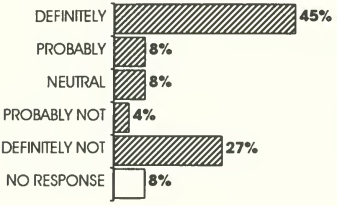
Abortion



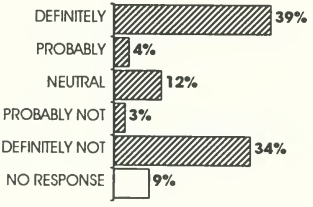
Abortion when medically necessary to save the mother's life



Abortion when pregnancy results from rape or incest

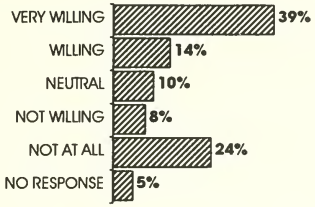


Abortion as an insurance benefit option that the individual would pay for separately

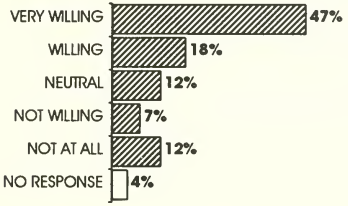


In order to extend health care coverage to more people and contain health care costs, how willing are you personally to...

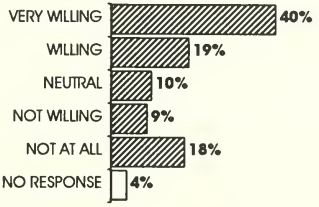
Make less frequent visits to your doctor



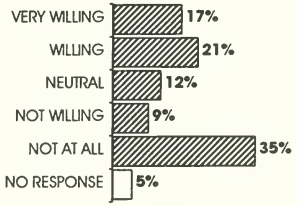
Make a co-payment for each doctor or hospital visit, and prescription



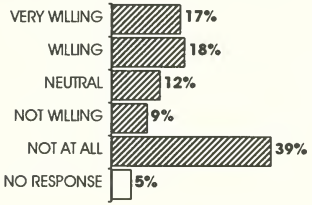
Wait longer for non-emergency appointments with your doctor



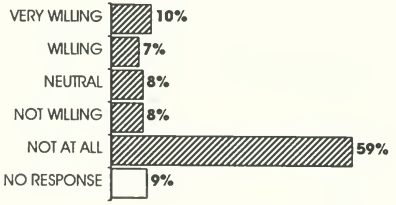
Accept some limitations on your access to most sophisticated medical technology



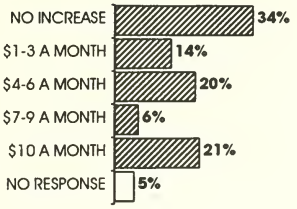
Accept some limitations on your choice of health care plans



Accept some limitations on your choice of physicians

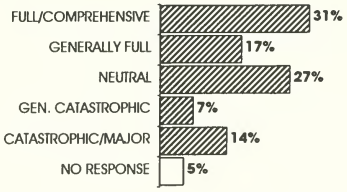


How much more, if anything, would you be willing to pay per month for your health care premium



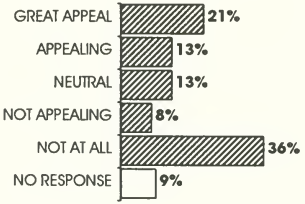
WRAP UP

What should be the primary purpose of health insurance?

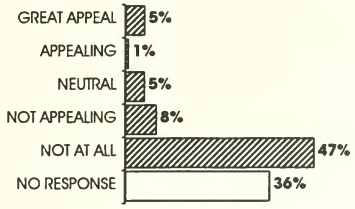


Indicate how much appeal each of the following health care plans has for you.

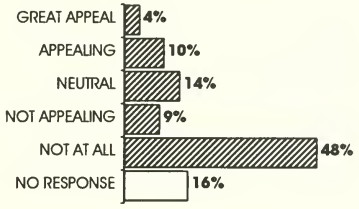
PLAN A would guarantee a standard package of health insurance benefits to all American citizens. Insurance companies would continue to provide health insurance coverage, with some government regulation to keep costs under control and to promote competition. All employers would be required to provide health insurance for their workers, with government subsidies to help small employers.



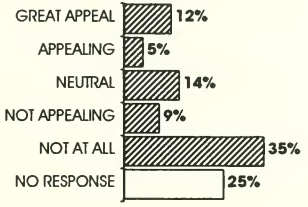
PLAN B: As an alternative to the type of health insurance coverage you have now, this plan would require the government to collect taxes from businesses and individuals and use the money to repay citizens for most medical expenses and to control the cost of medical services. Employers and insurance companies would not be involved.



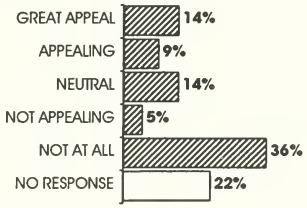
PLAN C would have the government require all individuals to have health insurance - similar to the requirement for all car owners to have auto insurance. Low income people would receive government financial assistance to help pay for their coverage.



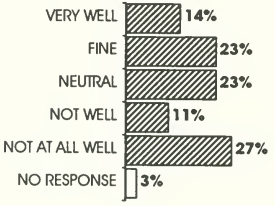
PLAN D would require all employers to offer a standard package of health care benefits, but would not require employers to pay any part of the costs. This plan would try to control costs by promoting market competition among insurance companies without government price control. It would not guarantee coverage for every citizen.



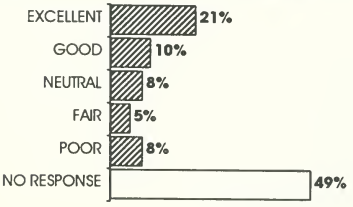
PLAN E: As an alternative to the type of health insurance coverage you receive now, individuals and/or employers could contribute $500 per year to a tax-deductible savings account which would be used to pay all preventive and primary care medical expenses. A catastrophic insurance plan would prove additional coverage for very high medical expenses. This plan would not directly control health care costs or provide coverage for all citizens.



How well do you understand the health care reform process in Montana at this time?



Overall, how would you rate your health care insurance coverage?



ELECTRONIC MEETING PROTOCOL

MONTANA HEALTH CARE AUTHORITY
CITIZEN ELECTRONIC FORUMS

SURVEY QUESTIONS

Demographic Information

1. Gender

   1=MALE
   2=FEMALE

2. Age (Set exact age)

3. Household make up

   1=Single, no children
   2=Couple, no children
   3=Single, children at home
   4=Couple, children at home
   5=Single, grown children
   6=Couple, grown children
   7=Other

4. Employment status

   1=Employed full time
   2=Employed part time
   3=Self employed
   4=Not currently working
   5=Retired
   6=Other

5. If employed...type of employer

   1=Public sector
   2=Agriculture/Natural resources
   3=Health care industry/Insurance
   4=Small business
   5=Other private sector
   6=Other
   7=Not employed

6. If employed...what is your occupation?

   1=Professional/Technical/Administrator
   2=Business/Sales
   3=Service
   4=Crafts/Labor/Blue collar
   5=Other
   6=Not employed

7. If employed...size of employer

   1=Work alone
   2=Fewer than 25 employees
   3=26-100
   4=101-500
   5=More than 500 employees
   6=Does not apply

8. Which of these best describes your current health insurance coverage?

   1=Not insured
   2=Insurance paid for ENTIRELY by self
   3=Insurance paid for PARTIALLY by employer
   4=Insurance paid for ENTIRELY by employer
   5=Medicare
   6=Medicaid
   7=Veterans
   8=Indian Health Services
   9=Other

9. Is your medical care provided by:

   1=Independent physician/Provider
   2=Health Maintenance Organization
   3=Preferred Provider System
   4=Government hospital
   5=Other
   6=Don't Know/No Answer

10. In the last 12 months, have you or any member of your household, received care from:

    1=Naturopathic

11. In the last 12 months, have you or any member of your household, received care from:

    1=Chiropractor

12. In the last 12 months, have you or any member of your household, received care from:

    1=Public health or School nurse

13. Have you or any member of your household, ever had health insurance coverage denied for financial reasons?

    1=Yes, self
    2=Yes, other in household
    3=No

14. At any time in the last 3 years have you, or anyone in your household, been without health insurance coverage?

    1=Yes, self
    2=Yes, other in household
    3=No

15. Do you, or any member of your household, have a serious medical problem or condition?

    1=Yes, self
    2=Yes, other in household
    3=No

16. Have you, or any member of your household, been hospitalized in the last 3 years?

    1=Yes, self
    2=Yes, other in household
    3=No

17. The Health Care System in Montana is in need of:

    1=Fundamental overhaul
    2=Major changes
    3=Minor changes
    4=No change
    5=No Opinion

Rate the following as goals of health care reform:

0=NOT AT ALL IMPORTANT ... 10=VERY IMPORTANT

18. Reduce waste/Inefficiency
19. Provide coverage between jobs
20. Reduce cost increase
21. Emphasize preventive care
22. Reduce malpractice suits
23. Improve overall quality of health care
24. Provide coverage for uninsured persons
25. Reduce cost of prescription drugs
26. If you had to chose one, which goal would you choose as the single most important goal of health care reform?

    1=Reduce waste/Inefficiency
    2=Provide coverage between jobs
    3=Reduce cost increase
    4=Emphasize preventive care
    5=Reduce malpractice suits
    6=Improve overall quality of health care
    7=Provide coverage for uninsured persons
    8=Reduce cost of prescription drugs
    9= None of the above

27. In your opinion which of the following has the greatest influence on how the health care system currently works in Montana?

    1=Physicians
    2=Hospitals
    3=Insurance companies
    4=Federal government
    5=State government
    6=Other
    7=No Opinion

28. The changes needed in the health care system would best be managed by:

    1=The health care industry as it currently exists
    2=State government
    3=Federal government
    4=A combination of government & the health care industry
    5=No Opinion

Impacts of Health Care Reform

We are going to list some concerns you might have about your own health care. We'll go through the list twice. The first time, indicate how you think each one might change under health care reform. The second time through the list, I will ask you how each might change if the health care reform system is not reformed.

29. Under health care reform, the quality of my health care ...
    +5 will go up ... -5 will go down
30. My taxes ...
    +5 will go up ... -5 will go down
31. My health care costs ...
    +5 will go up ... -5 will go down
32. My choice of provider ...
    +5 will go up ... -5 will go down
33. My health care benefits ...
    +5 will go up ... -5 will go down
34. The security of my coverage
    +5 will go up ... -5 will go down

NOW THE SAME LIST, ASSUMING THE HEALTH CARE SYSTEM STAYS AS IS

35. If the health care system is left as it is, the quality of my health care ...
    +5 will go up ... -5 will go down
36. My taxes ...
    +5 will go up ... -5 will go down
37. My health care costs ...
    +5 will go up ... -5 will go down
38. My choice of provider ...
    +5 will go up ... -5 will go down
39. My health care benefits ...
    +5 will go up ... -5 will go down
40. The security of my coverage
    +5 will go up ... -5 will go down

Cost

How much do each of the following contribute to the cost of health care:
0=NOTHING ... 10=A GREAT DEAL

41. Doctors' fees
42. Insurance companies
43. Hospital charges, excluding doctors' fees
44. New technology
45. Malpractice suits
46. Lab tests
47. Nursing homes & long term care
48. Medicine/pharmaceuticals
49. Administrative costs
50. Taking care of an aging population
51. Increased violence in society
52. Lack of incentive for consumers to save money
53. Consumers using health care services inappropriately
54. Health habits of individuals
55. Lifestyle choices if individuals

END OF SEGMENT ONE

Health Care Reform Concepts

Evaluate the following ideas about health care reform.

+5=LIKE VERY MUCH
0=DON'T UNDERSTAND
-5=DISLIKE VERY MUCH

56. Require all Montanans to have health care coverage
57. Require all Montanans to be responsible for his/her own coverage
58. Require all employers to be responsible for health care coverage for all their employees
59. Require employees to pay most of the average priced premium in the state.
60. Place a limit on the dollar amount that insurance premiums can increase each year
61. Regulate the fees charges by doctors and other providers
62. Regulate the fees charged by hospital

Are the following proposals a good idea or a bad idea, in your opinion.

63. No one could be denied health care coverage because of "pre-existing conditions."
64. No one could have their health care coverage cancelled for any reason (except failure to pay).
65. Employees could choose their own health care plans from among all plans offered, instead of from a list supplied by their employer.
66. Everyone would have the opportunity to change health care plans once a year.
67. Employees could keep their same coverage if they lost their job or changes jobs.

Health Care Reform Components

The following are major components of health care reform plans now being discussed. For each one, indicate how it sounds to you.

+5=LIKE VERY MUCH
0=DON'T UNDERSTAND
-5=DISLIKE VERY MUCH

68. **PURCHASING COOPERATIVE:** Large health insurance purchasing pools, organized by state or region, which contract with health care providers and/or insurance carriers to buy health services at a bulk rate to save money.
69. **INTEGRATED HEALTH SERVICE NETWORKS:** Organizations of health care providers (doctors, hospitals, insurance companies) which would group together to provide health care services to groups of consumers.
70. **GLOBAL BUDGET:** An administrative authority would establish a maximum amount of money to be spent by consumers on all health care services in the state each years. Such a process could either be voluntary or mandatory.
71. **CORE BENEFITS:** There would be a set of "core health care benefits" that everyone in the state would be entitled to as part of their insurance coverage. You could pay extra for additional (or supplemental) benefits.
72. **MEDICAL SAVING ACCOUNT:** Citizens could pay into a tax deductible "Health Care IRA" which would pay their insurance premiums, deductibles and co-pay, and uncovered expenses.

Core Health Insurance Benefits

Should the following be included in the "Core Benefits" provided to everyone in Montana.

+5=DEFINITLEY YES
-5=DEFINITELY NOT

73. Preventive care
74. Prescription drugs
75. Home care
76. Visits to doctors
77. Visits to physicians assistants & nurses practitioners
78. Emergency medical care
79. Surgery
80. Ambulance service
81. Dental care
82. Children's dental care
83. Eye or vision care
84. Hearing services
85. Laboratory/diagnostic services
86. Mental health treatment
87. Substance abuse treatment
88. Prosthetic or orthopedic services
89. Rehabilitative services
90. Acupuncture
91. Hospice care
92. Health education classes
93. Naturopathic care
94. Family planning education
95. Contraceptive services
96. Abortion
97. Abortion when medically necessary to save the mother's life
98. Abortion when pregnancy results from rape or incest
99. Abortion as an insurance benefit option that the individual would pay for separately

100. Should preventive care be provided without charge to individuals to encourage the use of preventive care? Or should there be a deductible or co-payment charge for preventive care, just as there is with other medical treatment and services? (Examples: immunizations, periodic physical exams, pre-natal and wellbaby care)

1=Free of Charge
2=Charge deductible or co-payment
3=No Answer

END OF SEGMENT TWO

IN ORDER TO EXTEND HEALTH CARE COVERAGE TO MORE PEOPLE AND CONTAIN HEALTH CARE COSTS, HOW WILLING ARE YOU PERSONALLY TO...

+5=VERY WILLING ... -5=NOT AT ALL WILLING

101. Make less frequent visits to your doctor
102. Make co-payment for each doctor or hospital visit, and prescription
103. Wait longer for non-emergency appointments with your doctor
104. Accept some limitations on your access to the most sophisticated medical technology
105. Accept some limitations on your choice of health care plans
106. Accept some limitations on your choice of physicians
107. How much more, if anything, would you be willing to pay per month for your health care premium? ($0 to $10 scale)
108. If the deductible amount on your health insurance were increased, would you be more likely to...

1=use fewer medical services
2=use the same amount of medical service as now
3=Not sure

109. If you had to pay a larger amount ($5 or $10) for each provider visit or prescription, would you be more likely to...

1=use fewer medical services
2=use the same amount of medical service as now
3=Not sure

Wrap Up

110. What should be the primary purpose of Health Insurance?

0=Cover catastrophic, or major events
10=Full and comprehensive health care coverage

111. **PLAN A** would guarantee a standard package of health insurance benefits to all American citizens. Insurance companies would continue to provide health insurance coverage, with some government regulation to keep costs under control and to promote competition. All employers would be required to provide health insurance for their workers, with government subsidies to help small employers.

112. **PLAN B:** As an alternative to the type of health insurance coverage you have now, this plan would require the government to collect taxes from businesses and individuals and use the money to repay citizens for most medical expenses and to control the cost of medical services. Employers and insurance companies would not be involved.

113. **PLAN C** would have the government require all individuals to have health insurance -- similar to the requirement for all car owners to have auto insurance. Low income people would receive government financial assistance to help them pay for their coverage.

114. **PLAN D** would require all employers to offer a standard package of health care benefits, but would not require employers to pay and part of the cost. This plan would try to control costs by promoting market competition among insurance companies without government price controls. It would not guarantee coverage for every citizen.

115. **PLAN E:** As an alternative to the type of health insurance coverage you receive now, individuals and/or employers could contribute $500 per year to a tax-deductible saving account which would be used to pay all preventive and primary care medical expenses. A catastrophic insurance plan would provide additional coverage for very high medical expenses. This plan would not directly control health care costs or provide coverage for all citizens.

116. How well do you understand the health care reform process in Montana at this time?

+5=VERY WELL
-5=NOT AT ALL

117. Overall, would you rate your health care insurance coverage...

+5=EXCELLENT
-5=POOR

DATA TABLES

READING THE CROSSTABULATION TABLES

The crosstabulations found in this report are presented in a "banner table" format. Categories of respondents (e.g."35-49 years old," or "Female") are listed across the top of each page (the "banner"). The questions asked in the survey are listed down the left margin. The figures in each cell are percentages based on the number of respondents in the category at the head of each column.

DEMOGRAPHIC CHARACTERISTICS
BY MEETING SITE

Q1-3	TOTAL	MEETING SITE		
		Glasgow	Great Falls	Kalispell
(n=)	155 100%	38 100%	63 100%	54 100%
GENDER				
Male	48 31%	14 37%	14 22%	20 37%
Female	69 45%	21 55%	17 27%	31 57%
No response	38 25%	3 8%	32 51%	3 6%
AGE				
Under 40	37 24%	9 24%	16 25%	12 22%
40-49	37 24%	7 18%	14 22%	16 30%
50-59	36 23%	12 32%	13 21%	11 20%
60 or over	38 25%	9 24%	15 24%	14 26%
No response	7 5%	1 3%	5 8%	1 2%
HOUSEHOLD COMPOSITION				
Single, no children	10 6%	1 3%	5 8%	4 7%
Single, children at home	9 6%	3 8%	3 5%	3 6%
Single, grown children	11 7%	4 11%	4 6%	3 6%
Couple, no children	12 8%	4 11%	5 8%	3 6%
Couple, children at home	50 32%	8 21%	21 33%	21 39%
Couple, grown children	51 33%	12 32%	22 35%	17 31%
Other	6 4%	2 5%	2 3%	2 4%
No response	6 4%	4 11%	1 2%	1 2%

EMPLOYMENT
BY MEETING SITE

Q4-7	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
EMPLOYMENT								
Employed full time	53	34%	11	29%	27	43%	15	28%
Employed part time	11	7%	2	5%	3	5%	6	11%
Self employed	35	23%	8	21%	9	14%	18	33%
Not currently working	13	8%	2	5%	7	11%	4	7%
Retired	37	24%	12	32%	16	25%	9	17%
Other	3	2%	1	3%	1	2%	1	2%
No response	3	2%	2	5%	0	0%	1	2%
EMPLOYER TYPE								
Public sector	24	15%	7	18%	12	19%	5	9%
Agriculture/natural resources	9	6%	3	8%	2	3%	4	7%
Health care/insurance	21	14%	3	8%	9	14%	9	17%
Small business	33	21%	7	18%	9	14%	17	31%
Other private sector	10	6%	2	5%	6	10%	2	4%
Other	5	3%	1	3%	2	3%	2	4%
Not employed	44	28%	12	32%	20	32%	12	22%
No response	9	6%	3	8%	3	5%	3	6%
OCCUPATION								
Professional/technical/adminis trator	46	30%	11	29%	20	32%	15	28%
Business/sales	25	16%	6	16%	8	13%	11	20%
Service	10	6%	1	3%	5	8%	4	7%
Crafts/labor/blue collar	14	9%	1	3%	6	10%	7	13%
Other	7	5%	3	8%	2	3%	2	4%
Not employed	43	28%	13	34%	17	27%	13	24%
No response	10	6%	3	8%	5	8%	2	4%
EMPLOYER SIZE								
Work alone	15	10%	4	11%	4	6%	7	13%
Fewer than 25 employees	40	26%	8	21%	13	21%	19	35%
26-100	10	6%	2	5%	7	11%	1	2%
101-500	8	5%	2	5%	1	2%	5	9%
More than 500	7	5%	0	0%	5	8%	2	4%
Does not apply	68	44%	20	53%	30	48%	18	33%
No response	7	5%	2	5%	3	5%	2	4%

HEALTH INSURANCE COVERAGE
BY MEETING SITE

Q8,9,117,13,14	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
CURRENT COVERAGE								
Not insured	14	9%	0	0%	6	10%	8	15%
Paid entirely by self	28	18%	6	16%	8	13%	14	26%
Paid partially by self & employer	55	35%	16	42%	25	40%	14	26%
Paid entirely by employer	14	9%	3	8%	5	8%	6	11%
Medicare	24	15%	6	16%	9	14%	9	17%
Medicaid	2	1%	1	3%	1	2%	0	0%
Indian Health Services	2	1%	1	3%	1	2%	0	0%
Other	6	4%	2	5%	2	3%	2	4%
No response	10	6%	3	8%	6	10%	1	2%
PROVIDER								
Independent physician/provider	89	57%	23	61%	28	44%	38	70%
Health maintenance system	22	14%	4	11%	12	19%	6	11%
Preferred provider system	13	8%	2	5%	8	13%	3	6%
Government hospital	5	3%	0	0%	5	8%	0	0%
Other	8	5%	2	5%	4	6%	2	4%
Not sure	11	7%	4	11%	4	6%	3	6%
No response	7	5%	3	8%	2	3%	2	4%
PERSONAL COVERAGE RATING								
Excellent	33	21%	0	0%	22	35%	11	20%
Good	15	10%	0	0%	8	13%	7	13%
Neutral	12	8%	0	0%	7	11%	5	9%
Fair	7	5%	0	0%	2	3%	5	9%
Poor	12	8%	0	0%	6	10%	6	11%
No response	76	49%	38	100%	18	29%	20	37%
DENIED COVERAGE								
Yes, self	8	5%	2	5%	4	6%	2	4%
Yes, other in household	4	3%	1	3%	3	5%	0	0%
No	138	89%	33	87%	56	89%	49	91%
No response	5	3%	2	5%	0	0%	3	6%
WITHOUT COVERAGE PAST 3 YEARS								
Yes, self	28	18%	6	16%	8	13%	14	26%
Yes, other in household	15	10%	5	13%	7	11%	3	6%
No	106	68%	25	66%	45	71%	36	67%
Not sure	1	1%	0	0%	1	2%	0	0%
No response	5	3%	2	5%	2	3%	1	2%

MEDICAL CARE EXPERIENCE
BY MEETING SITE

Q10,11,12,15,16	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
TREATED BY NATUROPATH								
Yes, self	13	8%	2	5%	4	6%	7	13%
Yes, other in household	9	6%	1	3%	3	5%	5	9%
No	109	70%	21	55%	50	79%	38	70%
Not sure	21	14%	12	32%	6	10%	3	6%
No response	3	2%	2	5%	0	0%	1	2%
TREATED BY CHIROPRACTOR								
Yes, self	42	27%	11	29%	14	22%	17	31%
Yes, other in household	16	10%	2	5%	8	13%	6	11%
No	94	61%	23	61%	41	65%	30	56%
No response	3	2%	2	5%	0	0%	1	2%
TREATED BY PUBLIC HEALTH OR SCHOOL NURSE								
Yes, self	11	7%	4	11%	4	6%	3	6%
Yes, other in household	19	12%	7	18%	8	13%	4	7%
No	116	75%	24	63%	47	75%	45	83%
Not sure	2	1%	0	0%	1	2%	1	2%
No response	7	5%	3	8%	3	5%	1	2%
SERIOUS MEDICAL PROBLEM								
Yes, self	27	17%	6	16%	12	19%	9	17%
Yes, other in household	36	23%	8	21%	16	25%	12	22%
No	83	54%	22	58%	32	51%	29	54%
Not sure	4	3%	0	0%	3	5%	1	2%
No response	5	3%	2	5%	0	0%	3	6%
HOSPITALIZED PAST 3 YEARS								
Yes, self	34	22%	4	11%	14	22%	16	30%
Yes, other in household	44	28%	12	32%	22	35%	10	19%
No	71	46%	18	47%	26	41%	27	50%
No response	6	4%	4	11%	1	2%	1	2%

HEALTH CARE REFORM NEED AND PRIORITIES, PART 1
BY MEETING SITE

Q17-22	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
MONTANA HEALTH CARE SYSTEM NEEDS:								
Fundamental overhaul	28	18%	8	21%	11	17%	9	17%
Major changes	40	26%	13	34%	10	16%	17	31%
Minor changes	53	34%	12	32%	19	30%	22	41%
No change	8	5%	3	8%	3	5%	2	4%
No answer	5	3%	0	0%	3	5%	2	4%
No response	21	14%	2	5%	17	27%	2	4%
REDUCE WASTE/INEFFICIENCY								
Very important	84	54%	26	68%	20	32%	38	70%
Important	17	11%	4	11%	5	8%	8	15%
Neutral	14	9%	7	18%	4	6%	3	6%
Not important	7	5%	1	3%	4	6%	2	4%
Not at all important	5	3%	0	0%	2	3%	3	6%
No response	28	18%	0	0%	28	44%	0	0%
PROVIDE COVERAGE BETWEEN JOBS								
Very important	59	38%	18	47%	18	29%	23	43%
Important	27	17%	6	16%	11	17%	10	19%
Neutral	19	12%	6	16%	7	11%	6	11%
Not important	14	9%	5	13%	3	5%	6	11%
Not at all important	15	10%	3	8%	6	10%	6	11%
No response	21	14%	0	0%	18	29%	3	6%
REDUCE COST INCREASES								
Very important	90	58%	30	79%	25	40%	35	65%
Important	20	13%	4	11%	9	14%	7	13%
Neutral	15	10%	2	5%	5	8%	8	15%
Not important	9	6%	2	5%	5	8%	2	4%
Not at all important	4	3%	0	0%	2	3%	2	4%
No response	17	11%	0	0%	17	27%	0	0%
EMPHASIZE PREVENTIVE CARE								
Very important	111	72%	23	61%	51	81%	37	69%
Important	22	14%	6	16%	9	14%	7	13%
Neutral	14	9%	6	16%	2	3%	6	11%
Not important	5	3%	3	8%	1	2%	1	2%
Not at all important	2	1%	0	0%	0	0%	2	4%
No response	1	1%	0	0%	0	0%	1	2%
REDUCE MALPRACTICE SUITS								
Very important	96	62%	24	63%	39	62%	33	61%
Important	29	19%	7	18%	10	16%	12	22%
Neutral	18	12%	4	11%	10	16%	4	7%
Not important	7	5%	3	8%	1	2%	3	6%
Not at all important	4	3%	0	0%	3	5%	1	2%
No response	1	1%	0	0%	0	0%	1	2%

HEALTH CARE REFORM PRIORITIES, PART 2
BY MEETING SITE

Q23-28	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
IMPROVE OVERALL HEALTH CARE QUALITY								
Very important	71	46%	15	39%	30	48%	26	48%
Important	28	18%	6	16%	12	19%	10	19%
Neutral	30	19%	9	24%	13	21%	8	15%
Not important	13	8%	5	13%	4	6%	4	7%
Not at all important	10	6%	1	3%	4	6%	5	9%
No response	3	2%	2	5%	0	0%	1	2%
PROVIDE COVERAGE FOR UNINSURED								
Very important	61	39%	13	34%	25	40%	23	43%
Important	28	18%	7	18%	14	22%	7	13%
Neutral	30	19%	7	18%	16	25%	7	13%
Not important	14	9%	6	16%	2	3%	6	11%
Not at all important	19	12%	3	8%	6	10%	10	19%
No response	3	2%	2	5%	0	0%	1	2%
REDUCE DRUG COSTS								
Very important	104	67%	27	71%	43	68%	34	63%
Important	15	10%	2	5%	6	10%	7	13%
Neutral	22	14%	6	16%	7	11%	9	17%
Not important	8	5%	2	5%	5	8%	1	2%
Not at all important	5	3%	0	0%	2	3%	3	6%
No response	1	1%	1	3%	0	0%	0	0%
MOST IMPORTANT GOAL								
Reduce waste and inefficiency	35	23%	10	26%	13	21%	12	22%
Provide coverage between jobs	7	5%	0	0%	4	6%	3	6%
Halt cost increases	38	25%	8	21%	13	21%	17	31%
Emphasize preventive care	14	9%	0	0%	7	11%	7	13%
Reduce malpractice suits	11	7%	3	8%	5	8%	3	6%
Improve overall quality	12	8%	4	11%	4	6%	4	7%
Provide coverage for uninsured	19	12%	7	18%	7	11%	5	9%
Reduce drug costs	7	5%	2	5%	3	5%	2	4%
None of these	2	1%	0	0%	2	3%	0	0%
No response	10	6%	4	11%	5	8%	1	2%
GREATEST INFLUENCE ON HEALTH SYSTEM								
Physicians	22	14%	7	18%	7	11%	8	15%
Hospitals	12	8%	2	5%	5	8%	5	9%
Insurance companies	74	48%	18	47%	33	52%	23	43%
Federal government	20	13%	4	11%	8	13%	8	15%
State government	7	5%	1	3%	3	5%	3	6%
Other	1	1%	0	0%	0	0%	1	2%
No response	19	12%	6	16%	7	11%	6	11%
BEST MANAGER OF SYSTEM CHANGES								
Current health industry	50	32%	11	29%	20	32%	19	35%
State government	8	5%	2	5%	1	2%	5	9%
Federal government	6	4%	0	0%	5	8%	1	2%
Government and health industry combination	64	41%	18	47%	34	54%	12	22%
No response	27	17%	7	18%	3	5%	17	31%

EFFECTS OF HEALTH CARE REFORM
BY MEETING SITE

Q29-34	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
UNDER REFORM, QUALITY WILL:								
Go up a lot	18	12%	2	5%	9	14%	7	13%
Go up	19	12%	4	11%	9	14%	6	11%
Neutral	38	25%	6	16%	14	22%	18	33%
Go down	25	16%	10	26%	11	17%	4	7%
Go down a lot	51	33%	14	37%	18	29%	19	35%
No response	4	3%	2	5%	2	3%	0	0%
UNDER REFORM, TAXES WILL:								
Go up a lot	109	70%	23	61%	41	65%	45	83%
Go up	29	19%	10	26%	13	21%	6	11%
Neutral	8	5%	0	0%	5	8%	3	6%
Go down	3	2%	2	5%	1	2%	0	0%
Go down a lot	4	3%	1	3%	3	5%	0	0%
No response	2	1%	2	5%	0	0%	0	0%
UNDER REFORM, COSTS WILL:								
Go up a lot	59	38%	6	16%	33	52%	20	37%
Go up	31	20%	9	24%	11	17%	11	20%
Neutral	39	25%	11	29%	14	22%	14	26%
Go down	11	7%	6	16%	2	3%	3	6%
Go down a lot	8	5%	2	5%	3	5%	3	6%
No response	7	5%	4	11%	0	0%	3	6%
UNDER REFORM, CHOICE OF PROVIDER WILL:								
Go up a lot	8	5%	1	3%	3	5%	4	7%
Go up	9	6%	1	3%	2	3%	6	11%
Neutral	43	28%	10	26%	16	25%	17	31%
Go down	26	17%	10	26%	11	17%	5	9%
Go down a lot	65	42%	13	34%	30	48%	22	41%
No response	4	3%	3	8%	1	2%	0	0%
UNDER REFORM, HEALTH CARE BENEFITS WILL:								
Go up a lot	19	12%	3	8%	5	8%	11	20%
Go up	11	7%	3	8%	3	5%	5	9%
Neutral	39	25%	8	21%	18	29%	13	24%
Go down	26	17%	10	26%	10	16%	6	11%
Go down a lot	50	32%	7	18%	26	41%	17	31%
No response	10	6%	7	18%	1	2%	2	4%
UNDER REFORM, SECURITY OF COVERAGE WILL:								
Go up a lot	34	22%	11	29%	12	19%	11	20%
Go up	24	15%	7	18%	10	16%	7	13%
Neutral	48	31%	9	24%	19	30%	20	37%
Go down	13	8%	4	11%	6	10%	3	6%
Go down a lot	29	19%	2	5%	15	24%	12	22%
No response	7	5%	5	13%	1	2%	1	2%

EFFECTS OF MAINTAINING STATUS QUO
BY MEETING SITE

Q35-40	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
WITH STATUS QUO, QUALITY WILL:								
Go up a lot	21	14%	4	11%	9	14%	8	15%
Go up	15	10%	4	11%	7	11%	4	7%
Neutral	76	49%	19	50%	29	46%	28	52%
Go down	18	12%	5	13%	6	10%	7	13%
Go down a lot	19	12%	1	3%	11	17%	7	13%
No response	6	4%	5	13%	1	2%	0	0%
WITH STATUS QUO, TAXES WILL:								
Go up a lot	45	29%	9	24%	22	35%	14	26%
Go up	38	25%	10	26%	18	29%	10	19%
Neutral	56	36%	12	32%	19	30%	25	46%
Go down	8	5%	4	11%	1	2%	3	6%
Go down a lot	4	3%	0	0%	2	3%	2	4%
No response	4	3%	3	8%	1	2%	0	0%
WITH STATUS QUO, COSTS WILL:								
Go up a lot	70	45%	15	39%	36	57%	19	35%
Go up	35	23%	12	32%	11	17%	12	22%
Neutral	37	24%	6	16%	10	16%	21	39%
Go down	4	3%	2	5%	1	2%	1	2%
Go down a lot	4	3%	0	0%	4	6%	0	0%
No response	5	3%	3	8%	1	2%	1	2%
WITH STATUS QUO, CHOICE OF PROVIDER WILL:								
Go up a lot	35	23%	6	16%	17	27%	12	22%
Go up	13	8%	2	5%	7	11%	4	7%
Neutral	80	52%	19	50%	30	48%	31	57%
Go down	12	8%	4	11%	4	6%	4	7%
Go down a lot	4	3%	0	0%	3	5%	1	2%
No response	11	7%	7	18%	2	3%	2	4%
WITH STATUS QUO, HEALTH CARE BENEFITS WILL:								
Go up a lot	9	6%	1	3%	6	10%	2	4%
Go up	10	6%	3	8%	2	3%	5	9%
Neutral	74	48%	15	39%	29	46%	30	56%
Go down	25	16%	8	21%	10	16%	7	13%
Go down a lot	29	19%	5	13%	15	24%	9	17%
No response	8	5%	6	16%	1	2%	1	2%
WITH STATUS QUO, SECURITY OF COVERAGE WILL:								
Go up a lot	11	7%	0	0%	7	11%	4	7%
Go up	5	3%	2	5%	1	2%	2	4%
Neutral	70	45%	11	29%	32	51%	27	50%
Go down	24	15%	11	29%	6	10%	7	13%
Go down a lot	34	22%	9	24%	15	24%	10	19%
No response	11	7%	5	13%	2	3%	4	7%

HEALTH CARE COST CONTRIBUTORS, PART 1
BY MEETING SITE

Q41-46	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
DOCTOR FEES								
Contributes a great deal	54	35%	10	26%	23	37%	21	39%
Contributes some	44	28%	11	29%	15	24%	18	33%
Neutral	42	27%	11	29%	21	33%	10	19%
Contributes little	8	5%	3	8%	1	2%	4	7%
Contributes nothing to health care costs	2	1%	0	0%	1	2%	1	2%
No response	5	3%	3	8%	2	3%	0	0%
INSURANCE CO. COSTS								
Contributes a great deal	83	54%	12	32%	39	62%	32	59%
Contributes some	29	19%	9	24%	11	17%	9	17%
Neutral	23	15%	9	24%	9	14%	5	9%
Contributes little	9	6%	3	8%	2	3%	4	7%
Contributes nothing to health care costs	3	2%	0	0%	1	2%	2	4%
No response	8	5%	5	13%	1	2%	2	4%
HOSPITAL CHARGES								
Contributes a great deal	104	67%	22	58%	38	60%	44	81%
Contributes some	30	19%	5	13%	18	29%	7	13%
Neutral	9	6%	2	5%	5	8%	2	4%
Contributes little	3	2%	2	5%	0	0%	1	2%
No response	9	6%	7	18%	2	3%	0	0%
NEW TECHNOLOGY								
Contributes a great deal	70	45%	11	29%	33	52%	26	48%
Contributes some	40	26%	9	24%	15	24%	16	30%
Neutral	22	14%	7	18%	10	16%	5	9%
Contributes little	7	5%	1	3%	3	5%	3	6%
Contributes nothing to health care costs	5	3%	2	5%	1	2%	2	4%
No response	11	7%	8	21%	1	2%	2	4%
MALPRACTICE LAW SUITS								
Contributes a great deal	87	56%	16	42%	39	62%	32	59%
Contributes some	28	18%	5	13%	10	16%	13	24%
Neutral	20	13%	5	13%	8	13%	7	13%
Contributes little	8	5%	3	8%	4	6%	1	2%
Contributes nothing to health care costs	4	3%	3	8%	0	0%	1	2%
No response	8	5%	6	16%	2	3%	0	0%
LAB TESTS								
Contributes a great deal	33	21%	6	16%	15	24%	12	22%
Contributes some	48	31%	12	32%	22	35%	14	26%
Neutral	47	30%	8	21%	18	29%	21	39%
Contributes little	11	7%	3	8%	4	6%	4	7%
Contributes nothing to health care costs	5	3%	1	3%	2	3%	2	4%
No response	11	7%	8	21%	2	3%	1	2%

HEALTH CARE COST CONTRIBUTORS, PART 2
BY MEETING SITE

Q47-52	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
NURSING HOMES								
Contributes a great deal	62	40%	9	24%	31	49%	22	41%
Contributes some	37	24%	11	29%	11	17%	15	28%
Neutral	30	19%	6	16%	13	21%	11	20%
Contributes little	9	6%	4	11%	2	3%	3	6%
Contributes nothing to health care costs	6	4%	0	0%	3	5%	3	6%
No response	11	7%	8	21%	3	5%	0	0%
MEDICINE/DRUGS								
Contributes a great deal	64	41%	13	34%	29	46%	22	41%
Contributes some	45	29%	8	21%	18	29%	19	35%
Neutral	26	17%	4	11%	13	21%	9	17%
Contributes little	9	6%	5	13%	2	3%	2	4%
Contributes nothing to health care costs	2	1%	1	3%	0	0%	1	2%
No response	9	6%	7	18%	1	2%	1	2%
ADMINISTRATIVE COSTS								
Contributes a great deal	78	50%	15	39%	31	49%	32	59%
Contributes some	36	23%	4	11%	19	30%	13	24%
Neutral	24	15%	8	21%	10	16%	6	11%
Contributes little	8	5%	3	8%	2	3%	3	6%
No response	9	6%	8	21%	1	2%	0	0%
CARE OF AGING POPULATION								
Contributes a great deal	73	47%	12	32%	37	59%	24	44%
Contributes some	32	21%	8	21%	13	21%	11	20%
Neutral	37	24%	11	29%	9	14%	17	31%
Contributes little	4	3%	2	5%	1	2%	1	2%
Contributes nothing to health care costs	2	1%	0	0%	2	3%	0	0%
No response	7	5%	5	13%	1	2%	1	2%
INCREASED VIOLENCE								
Contributes a great deal	46	30%	6	16%	21	33%	19	35%
Contributes some	41	26%	10	26%	21	33%	10	19%
Neutral	41	26%	8	21%	15	24%	18	33%
Contributes little	12	8%	5	13%	2	3%	5	9%
Contributes nothing to health care costs	5	3%	1	3%	2	3%	2	4%
No response	10	6%	8	21%	2	3%	0	0%
LOW CONSUMER SAVINGS								
Contributes a great deal	39	25%	6	16%	19	30%	14	26%
Contributes some	28	18%	10	26%	8	13%	10	19%
Neutral	42	27%	9	24%	21	33%	12	22%
Contributes little	18	12%	4	11%	6	10%	8	15%
Contributes nothing to health care costs	20	13%	3	8%	7	11%	10	19%
No response	8	5%	6	16%	2	3%	0	0%

HEALTH CARE COST CONTRIBUTORS, PART 3
BY MEETING SITE

Q53-55	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
MISUSE OF HEALTH SERVICES								
Contributes a great deal	61	39%	9	24%	25	40%	27	50%
Contributes some	33	21%	10	26%	15	24%	8	15%
Neutral	26	17%	6	16%	11	17%	9	17%
Contributes little	19	12%	4	11%	9	14%	6	11%
Contributes nothing to health care costs	8	5%	2	5%	2	3%	4	7%
No response	8	5%	7	18%	1	2%	0	0%
HEALTH HABITS								
Contributes a great deal	65	42%	7	18%	32	51%	26	48%
Contributes some	44	28%	11	29%	20	32%	13	24%
Neutral	25	16%	6	16%	9	14%	10	19%
Contributes little	7	5%	4	11%	0	0%	3	6%
Contributes nothing to health care costs	3	2%	1	3%	1	2%	1	2%
No response	11	7%	9	24%	1	2%	1	2%
LIFESTYLE CHOICES								
Contributes a great deal	57	37%	5	13%	34	54%	18	33%
Contributes some	37	24%	6	16%	15	24%	16	30%
Neutral	31	20%	10	26%	11	17%	10	19%
Contributes little	11	7%	6	16%	1	2%	4	7%
Contributes nothing to health care costs	5	3%	1	3%	1	2%	3	6%
No response	14	9%	10	26%	1	2%	3	6%

OPINIONS ON HEALTH CARE REFORM CONCEPTS, PART 1
BY MEETING SITE

Q56-61	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
REQUIRED COVERAGE								
Like very much	32	21%	11	29%	13	21%	8	15%
Like	22	14%	2	5%	10	16%	10	19%
Neutral	16	10%	4	11%	6	10%	6	11%
Dislike	11	7%	3	8%	6	10%	2	4%
Dislike very much	45	29%	6	16%	22	35%	17	31%
Don't understand	10	6%	3	8%	4	6%	3	6%
No response	19	12%	9	24%	2	3%	8	15%
PERSONAL RESPONSIBILITY FOR COVERAGE								
Like very much	42	27%	6	16%	20	32%	16	30%
Like	19	12%	3	8%	10	16%	6	11%
Neutral	12	8%	1	3%	5	8%	6	11%
Dislike	20	13%	8	21%	7	11%	5	9%
Dislike very much	36	23%	9	24%	17	27%	10	19%
Don't understand	8	5%	1	3%	3	5%	4	7%
No response	18	12%	10	26%	1	2%	7	13%
EMPLOYER RESPONSIBILITY								
Like very much	17	11%	4	11%	8	13%	5	9%
Like	21	14%	8	21%	7	11%	6	11%
Neutral	7	5%	1	3%	3	5%	3	6%
Dislike	23	15%	3	8%	10	16%	10	19%
Dislike very much	65	42%	11	29%	33	52%	21	39%
Don't understand	1	1%	0	0%	0	0%	1	2%
No response	21	14%	11	29%	2	3%	8	15%
REQUIRE EMPLOYEES TO PAY								
Like very much	25	16%	3	8%	10	16%	12	22%
Like	21	14%	6	16%	8	13%	7	13%
Neutral	17	11%	2	5%	9	14%	6	11%
Dislike	18	12%	4	11%	8	13%	6	11%
Dislike very much	45	29%	8	21%	24	38%	13	24%
Don't understand	3	2%	0	0%	3	5%	0	0%
No response	26	17%	15	39%	1	2%	10	19%
LIMIT PREMIUM INCREASES								
Like very much	94	61%	21	55%	37	59%	36	67%
Like	19	12%	4	11%	13	21%	2	4%
Neutral	6	4%	0	0%	4	6%	2	4%
Dislike	3	2%	1	3%	2	3%	0	0%
Dislike very much	12	8%	0	0%	7	11%	5	9%
Don't understand	1	1%	1	3%	0	0%	0	0%
No response	20	13%	11	29%	0	0%	9	17%
REGULATE DOCTOR FEES								
Like very much	58	37%	14	37%	26	41%	18	33%
Like	29	19%	5	13%	12	19%	12	22%
Neutral	4	3%	1	3%	1	2%	2	4%
Dislike	2	1%	2	5%	0	0%	0	0%
Dislike very much	29	19%	1	3%	17	27%	11	20%
Don't understand	7	5%	0	0%	4	6%	3	6%
No response	26	17%	15	39%	3	5%	8	15%

OPINIONS ON HEALTH CARE REFORM CONCEPTS, PART 2
BY MEETING SITE

Q62-67	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
REGULATE HOSPITAL FEES								
Like very much	68	44%	21	55%	22	35%	25	46%
Like	25	16%	1	3%	17	27%	7	13%
Neutral	2	1%	1	3%	1	2%	0	0%
Dislike	7	5%	1	3%	4	6%	2	4%
Dislike very much	24	15%	0	0%	15	24%	9	17%
Don't understand	2	1%	0	0%	1	2%	1	2%
No response	27	17%	14	37%	3	5%	10	19%
NO DENIAL FOR PRIOR CONDITION								
Like very much	90	58%	16	42%	44	70%	30	56%
Like	19	12%	5	13%	10	16%	4	7%
Neutral	4	3%	0	0%	1	2%	3	6%
Dislike	8	5%	1	3%	4	6%	3	6%
Dislike very much	9	6%	1	3%	4	6%	4	7%
Don't understand	1	1%	0	0%	0	0%	1	2%
No response	24	15%	15	39%	0	0%	9	17%
NO COVERAGE CANCELLATION								
Like very much	102	66%	17	45%	47	75%	38	70%
Like	14	9%	3	8%	8	13%	3	6%
Neutral	4	3%	1	3%	2	3%	1	2%
Dislike	1	1%	1	3%	0	0%	0	0%
Dislike very much	9	6%	3	8%	6	10%	0	0%
Don't understand	1	1%	0	0%	0	0%	1	2%
No response	24	15%	13	34%	0	0%	11	20%
EMPLOYEE CHOICE OF ALL PLANS								
Like very much	71	46%	11	29%	42	67%	18	33%
Like	25	16%	7	18%	7	11%	11	20%
Neutral	8	5%	1	3%	5	8%	2	4%
Dislike	6	4%	2	5%	2	3%	2	4%
Dislike very much	15	10%	1	3%	6	10%	8	15%
Don't understand	3	2%	2	5%	0	0%	1	2%
No response	27	17%	14	37%	1	2%	12	22%
YEARLY OPPORTUNITY TO CHANGE PLANS								
Like very much	41	26%	8	21%	15	24%	18	33%
Like	16	10%	2	5%	6	10%	8	15%
Neutral	5	3%	0	0%	2	3%	3	6%
Dislike	13	8%	6	16%	3	5%	4	7%
Dislike very much	12	8%	2	5%	6	10%	4	7%
Don't understand	11	7%	3	8%	4	6%	4	7%
No response	57	37%	17	45%	27	43%	13	24%
EMPLOYEES CAN RETAIN COVERAGE								
Like very much	67	43%	0	0%	37	59%	30	56%
Like	17	11%	0	0%	14	22%	3	6%
Neutral	4	3%	0	0%	3	5%	1	2%
Dislike	1	1%	0	0%	1	2%	0	0%
Dislike very much	5	3%	0	0%	2	3%	3	6%
Don't understand	6	4%	0	0%	4	6%	2	4%
No response	55	35%	38	100%	2	3%	15	28%

OPINIONS ON HEALTH CARE REFORM COMPONENTS
BY MEETING SITE

Q68-72	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
PURCHASING COOPERATIVES								
Like very much	45	29%	5	13%	21	33%	19	35%
Like	19	12%	6	16%	10	16%	3	6%
Neutral	7	5%	2	5%	3	5%	2	4%
Dislike	11	7%	5	13%	4	6%	2	4%
Dislike very much	32	21%	4	11%	18	29%	10	19%
Don't understand	16	10%	5	13%	6	10%	5	9%
No response	25	16%	11	29%	1	2%	13	24%
INTEGRATED NETWORKS								
Like very much	37	24%	6	16%	17	27%	14	26%
Like	12	8%	2	5%	5	8%	5	9%
Neutral	16	10%	4	11%	7	11%	5	9%
Dislike	8	5%	2	5%	5	8%	1	2%
Dislike very much	35	23%	4	11%	24	38%	7	13%
Don't understand	19	12%	6	16%	4	6%	9	17%
No response	28	18%	14	37%	1	2%	13	24%
GLOBAL BUDGET								
Like very much	12	8%	1	3%	7	11%	4	7%
Like	3	2%	2	5%	0	0%	1	2%
Neutral	8	5%	1	3%	3	5%	4	7%
Dislike	12	8%	4	11%	4	6%	4	7%
Dislike very much	77	50%	13	34%	41	65%	23	43%
Don't understand	15	10%	4	11%	7	11%	4	7%
No response	28	18%	13	34%	1	2%	14	26%
CORE BENEFITS								
Like very much	57	37%	8	21%	28	44%	21	39%
Like	27	17%	7	18%	10	16%	10	19%
Neutral	9	6%	4	11%	4	6%	1	2%
Dislike	10	6%	4	11%	5	8%	1	2%
Dislike very much	13	8%	1	3%	8	13%	4	7%
Don't understand	9	6%	2	5%	4	6%	3	6%
No response	30	19%	12	32%	4	6%	14	26%
MEDICAL SAVINGS ACCOUNT								
Like very much	61	39%	9	24%	28	44%	24	44%
Like	28	18%	8	21%	17	27%	3	6%
Neutral	4	3%	2	5%	1	2%	1	2%
Dislike	5	3%	1	3%	2	3%	2	4%
Dislike very much	14	9%	4	11%	6	10%	4	7%
Don't understand	12	8%	3	8%	6	10%	3	6%
No response	31	20%	11	29%	3	5%	17	31%

CORE HEALTH INSURANCE BENEFITS, PART 1
BY MEETING SITE

Q73-78	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
PREVENTIVE CARE								
Definitely core benefit	96	62%	16	42%	48	76%	32	59%
Probably	14	9%	5	13%	6	10%	3	6%
Neutral	9	6%	4	11%	3	5%	2	4%
Probably not	5	3%	2	5%	2	3%	1	2%
Definitely not	6	4%	1	3%	3	5%	2	4%
No response	25	16%	10	26%	1	2%	14	26%
DRUGS								
Definitely core benefit	63	41%	10	26%	37	59%	16	30%
Probably	25	16%	5	13%	12	19%	8	15%
Neutral	14	9%	2	5%	5	8%	7	13%
Probably not	7	5%	2	5%	1	2%	4	7%
Definitely not	15	10%	4	11%	7	11%	4	7%
No response	31	20%	15	39%	1	2%	15	28%
HOME CARE								
Definitely core benefit	51	33%	8	21%	27	43%	16	30%
Probably	23	15%	6	16%	12	19%	5	9%
Neutral	23	15%	4	11%	10	16%	9	17%
Probably not	15	10%	3	8%	8	13%	4	7%
Definitely not	12	8%	3	8%	5	8%	4	7%
No response	31	20%	14	37%	1	2%	16	30%
DOCTOR VISITS								
Definitely core benefit	75	48%	10	26%	42	67%	23	43%
Probably	27	17%	9	24%	10	16%	8	15%
Neutral	14	9%	5	13%	7	11%	2	4%
Probably not	4	3%	1	3%	2	3%	1	2%
Definitely not	6	4%	1	3%	1	2%	4	7%
No response	29	19%	12	32%	1	2%	16	30%
PHYSICIAN ASSISTANTS								
Definitely core benefit	58	37%	8	21%	30	48%	20	37%
Probably	21	14%	5	13%	9	14%	7	13%
Neutral	24	15%	3	8%	17	27%	4	7%
Probably not	7	5%	2	5%	3	5%	2	4%
Definitely not	9	6%	2	5%	2	3%	5	9%
No response	36	23%	18	47%	2	3%	16	30%
EMERGENCY CARE								
Definitely core benefit	94	61%	16	42%	50	79%	28	52%
Probably	11	7%	2	5%	7	11%	2	4%
Neutral	9	6%	3	8%	3	5%	3	6%
Probably not	2	1%	1	3%	1	2%	0	0%
Definitely not	5	3%	0	0%	0	0%	5	9%
No response	34	22%	16	42%	2	3%	16	30%

CORE HEALTH INSURANCE BENEFITS, PART 2
BY MEETING SITE

Q79-84	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
SURGERY								
Definitely core benefit	85	55%	14	37%	44	70%	27	50%
Probably	15	10%	3	8%	10	16%	2	4%
Neutral	10	6%	3	8%	5	8%	2	4%
Probably not	2	1%	1	3%	0	0%	1	2%
Definitely not	8	5%	0	0%	2	3%	6	11%
No response	35	23%	17	45%	2	3%	16	30%
AMBULANCE SERVICE								
Definitely core benefit	49	32%	8	21%	27	43%	14	26%
Probably	23	15%	5	13%	12	19%	6	11%
Neutral	19	12%	5	13%	10	16%	4	7%
Probably not	6	4%	2	5%	2	3%	2	4%
Definitely not	26	17%	4	11%	11	17%	11	20%
No response	32	21%	14	37%	1	2%	17	31%
DENTAL CARE								
Definitely core benefit	37	24%	6	16%	22	35%	9	17%
Probably	17	11%	5	13%	6	10%	6	11%
Neutral	25	16%	7	18%	13	21%	5	9%
Probably not	10	6%	4	11%	5	8%	1	2%
Definitely not	36	23%	5	13%	15	24%	16	30%
No response	30	19%	11	29%	2	3%	17	31%
CHILDREN'S DENTAL CARE								
Definitely core benefit	47	30%	7	18%	25	40%	15	28%
Probably	22	14%	6	16%	10	16%	6	11%
Neutral	20	13%	4	11%	12	19%	4	7%
Probably not	11	7%	3	8%	4	6%	4	7%
Definitely not	21	14%	5	13%	9	14%	7	13%
No response	34	22%	13	34%	3	5%	18	33%
EYE CARE								
Definitely core benefit	46	30%	6	16%	24	38%	16	30%
Probably	22	14%	7	18%	11	17%	4	7%
Neutral	18	12%	6	16%	6	10%	6	11%
Probably not	13	8%	3	8%	7	11%	3	6%
Definitely not	25	16%	6	16%	11	17%	8	15%
No response	31	20%	10	26%	4	6%	17	31%
HEARING SERVICES								
Definitely core benefit	28	18%	3	8%	15	24%	10	19%
Probably	23	15%	4	11%	15	24%	4	7%
Neutral	24	15%	4	11%	13	21%	7	13%
Probably not	8	5%	3	8%	5	8%	0	0%
Definitely not	32	21%	5	13%	12	19%	15	28%
No response	40	26%	19	50%	3	5%	18	33%

CORE HEALTH INSURANCE BENEFITS, PART 3
BY MEETING SITE

Q85-90	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
LABORATORY SERVICES								
Definitely core benefit	84	54%	18	47%	43	68%	23	43%
Probably	13	8%	1	3%	9	14%	3	6%
Neutral	13	8%	5	13%	6	10%	2	4%
Probably not	8	5%	2	5%	3	5%	3	6%
Definitely not	7	5%	1	3%	1	2%	5	9%
No response	30	19%	11	29%	1	2%	18	33%
MENTAL HEALTH								
Definitely core benefit	36	23%	7	18%	17	27%	12	22%
Probably	21	14%	6	16%	11	17%	4	7%
Neutral	21	14%	8	21%	11	17%	2	4%
Probably not	8	5%	2	5%	3	5%	3	6%
Definitely not	39	25%	4	11%	20	32%	15	28%
No response	30	19%	11	29%	1	2%	18	33%
SUBSTANCE ABUSE								
Definitely core benefit	25	16%	8	21%	14	22%	3	6%
Probably	18	12%	3	8%	9	14%	6	11%
Neutral	13	8%	6	16%	4	6%	3	6%
Probably not	13	8%	6	16%	6	10%	1	2%
Definitely not	55	35%	4	11%	27	43%	24	44%
No response	31	20%	11	29%	3	5%	17	31%
PROSTHETIC SERVICES								
Definitely core benefit	42	27%	8	21%	22	35%	12	22%
Probably	19	12%	1	3%	12	19%	6	11%
Neutral	30	19%	9	24%	11	17%	10	19%
Probably not	9	6%	3	8%	4	6%	2	4%
Definitely not	19	12%	2	5%	11	17%	6	11%
No response	36	23%	15	39%	3	5%	18	33%
REHABILITATIVE SERVICES								
Definitely core benefit	38	25%	4	11%	21	33%	13	24%
Probably	28	18%	4	11%	18	29%	6	11%
Neutral	21	14%	7	18%	8	13%	6	11%
Probably not	13	8%	6	16%	5	8%	2	4%
Definitely not	19	12%	1	3%	8	13%	10	19%
No response	36	23%	16	42%	3	5%	17	31%
ACUPUNCTURE								
Definitely core benefit	8	5%	1	3%	5	8%	2	4%
Probably	6	4%	3	8%	1	2%	2	4%
Neutral	14	9%	2	5%	9	14%	3	6%
Probably not	15	10%	3	8%	7	11%	5	9%
Definitely not	68	44%	8	21%	36	57%	24	44%
No response	44	28%	21	55%	5	8%	18	33%

CORE HEALTH INSURANCE BENEFITS, PART 4
BY MEETING SITE

Q91-95	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
HOSPICE CARE								
Definitely core benefit	47	30%	3	8%	28	44%	16	30%
Probably	19	12%	5	13%	12	19%	2	4%
Neutral	23	15%	6	16%	11	17%	6	11%
Probably not	12	8%	8	21%	2	3%	2	4%
Definitely not	22	14%	3	8%	9	14%	10	19%
No response	32	21%	13	34%	1	2%	18	33%
HEALTH EDUCATION								
Definitely core benefit	30	19%	10	26%	12	19%	8	15%
Probably	12	8%	0	0%	8	13%	4	7%
Neutral	20	13%	7	18%	7	11%	6	11%
Probably not	11	7%	5	13%	4	6%	2	4%
Definitely not	56	36%	12	32%	29	46%	15	28%
No response	26	17%	4	11%	3	5%	19	35%
NATUROPATHIC CARE								
Definitely core benefit	25	16%	4	11%	13	21%	8	15%
Probably	15	10%	4	11%	7	11%	4	7%
Neutral	17	11%	7	18%	4	6%	6	11%
Probably not	12	8%	5	13%	5	8%	2	4%
Definitely not	52	34%	6	16%	31	49%	15	28%
No response	34	22%	12	32%	3	5%	19	35%
FAMILY PLANNING								
Definitely core benefit	34	22%	6	16%	18	29%	10	19%
Probably	15	10%	5	13%	5	8%	5	9%
Neutral	18	12%	6	16%	8	13%	4	7%
Probably not	14	9%	6	16%	3	5%	5	9%
Definitely not	65	42%	10	26%	26	41%	29	54%
No response	9	6%	5	13%	3	5%	1	2%
CONTRACEPTIVE SERVICES								
Definitely core benefit	38	25%	5	13%	18	29%	15	28%
Probably	5	3%	2	5%	2	3%	1	2%
Neutral	9	6%	6	16%	2	3%	1	2%
Probably not	13	8%	5	13%	5	8%	3	6%
Definitely not	76	49%	13	34%	31	49%	32	59%
No response	14	9%	7	18%	5	8%	2	4%

CORE HEALTH INSURANCE BENEFITS, PART 5
BY MEETING SITE

Q96-100	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
ABORTION								
Definitely core benefit	26	17%	3	8%	12	19%	11	20%
Probably	4	3%	1	3%	2	3%	1	2%
Neutral	10	6%	3	8%	3	5%	4	7%
Probably not	8	5%	6	16%	0	0%	2	4%
Definitely not	92	59%	15	39%	43	68%	34	63%
No response	15	10%	10	26%	3	5%	2	4%
ABORTION TO SAVE LIFE								
Definitely core benefit	84	54%	19	50%	35	56%	30	56%
Probably	15	10%	5	13%	6	10%	4	7%
Neutral	17	11%	2	5%	10	16%	5	9%
Probably not	9	6%	4	11%	5	8%	0	0%
Definitely not	22	14%	2	5%	6	10%	14	26%
No response	8	5%	6	16%	1	2%	1	2%
ABORTION FOR RAPE								
Definitely core benefit	70	45%	11	29%	30	48%	29	54%
Probably	12	8%	6	16%	3	5%	3	6%
Neutral	13	8%	4	11%	5	8%	4	7%
Probably not	6	4%	2	5%	4	6%	0	0%
Definitely not	41	26%	7	18%	17	27%	17	31%
No response	13	8%	8	21%	4	6%	1	2%
ABORTION, BUT SELF-PAID								
Definitely core benefit	60	39%	16	42%	22	35%	22	41%
Probably	6	4%	2	5%	2	3%	2	4%
Neutral	18	12%	3	8%	8	13%	7	13%
Probably not	5	3%	3	8%	1	2%	1	2%
Definitely not	52	34%	7	18%	26	41%	19	35%
No response	14	9%	7	18%	4	6%	3	6%
PREVENTIVE CARE PROVISION								
No charge	49	32%	6	16%	22	35%	21	39%
Same as other care	74	48%	24	63%	25	40%	25	46%
No answer	3	2%	2	5%	0	0%	1	2%
No response	29	19%	6	16%	16	25%	7	13%

WILLING TO DO TO EXTEND HEALTH CARE COVERAGE
BY MEETING SITE

Q101-106	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
MAKE FEWER DOCTOR VISITS								
Very willing	61	39%	15	39%	24	38%	22	41%
Willing	22	14%	5	13%	13	21%	4	7%
Neutral	16	10%	3	8%	8	13%	5	9%
Not willing	12	8%	3	8%	3	5%	6	11%
Not at all willing	37	24%	9	24%	13	21%	15	28%
No response	7	5%	3	8%	2	3%	2	4%
MAKE CO-PAYMENTS								
Very willing	73	47%	13	34%	30	48%	30	56%
Willing	28	18%	5	13%	18	29%	5	9%
Neutral	19	12%	3	8%	5	8%	11	20%
Not willing	10	6%	4	11%	4	6%	2	4%
Not at all willing	19	12%	9	24%	5	8%	5	9%
No response	6	4%	4	11%	1	2%	1	2%
WAIT LONGER FOR APPOINTMENTS								
Very willing	62	40%	13	34%	25	40%	24	44%
Willing	30	19%	5	13%	14	22%	11	20%
Neutral	15	10%	3	8%	8	13%	4	7%
Not willing	14	9%	6	16%	4	6%	4	7%
Not at all willing	28	18%	8	21%	11	17%	9	17%
No response	6	4%	3	8%	1	2%	2	4%
ACCEPT LIMITATIONS ON ACCESS								
Very willing	27	17%	6	16%	8	13%	13	24%
Willing	33	21%	6	16%	16	25%	11	20%
Neutral	19	12%	6	16%	8	13%	5	9%
Not willing	14	9%	6	16%	6	10%	2	4%
Not at all willing	54	35%	10	26%	22	35%	22	41%
No response	8	5%	4	11%	3	5%	1	2%
ACCEPT LIMITATIONS ON CHOICE OF PLANS								
Very willing	27	17%	5	13%	8	13%	14	26%
Willing	28	18%	10	26%	11	17%	7	13%
Neutral	18	12%	6	16%	7	11%	5	9%
Not willing	14	9%	4	11%	9	14%	1	2%
Not at all willing	60	39%	9	24%	25	40%	26	48%
No response	8	5%	4	11%	3	5%	1	2%
ACCEPT LIMITATIONS ON CHOICE OF DOCTOR								
Very willing	15	10%	4	11%	5	8%	6	11%
Willing	10	6%	2	5%	6	10%	2	4%
Neutral	12	8%	4	11%	5	8%	3	6%
Not willing	13	8%	6	16%	5	8%	2	4%
Not at all willing	91	59%	12	32%	39	62%	40	74%
No response	14	9%	10	26%	3	5%	1	2%

WILLINGNESS TO PAY TO EXTEND COVERAGE, ETC.
BY MEETING SITE

Q107-110	TOTAL	MEETING SITE		
		Glasgow	Great Falls	Kalispell
(n=)	155 100%	38 100%	63 100%	54 100%
PREMIUM INCREASE FOR EXTENDING COVERAGE				
No increase acceptable	52 34%	11 29%	21 33%	20 37%
$1-$3/month	22 14%	8 21%	6 10%	8 15%
$4-$6/month	31 20%	6 16%	15 24%	10 19%
$7-$9/month	9 6%	2 5%	5 8%	2 4%
$10/month	33 21%	6 16%	14 22%	13 24%
No response	8 5%	5 13%	2 3%	1 2%
EFFECT OF INCREASED DEDUCTIBLE				
Use fewer medical services	19 12%	8 21%	0 0%	11 20%
Use the same amount as now	62 40%	23 61%	0 0%	39 72%
Not sure	8 5%	5 13%	0 0%	3 6%
No response	66 43%	2 5%	63 100%	1 2%
EFFECT OF PAYING MORE FOR VISITS/DRUGS				
Use fewer medical services	30 19%	8 21%	12 19%	10 19%
Use the same amount as now	107 69%	26 68%	45 71%	36 67%
Not sure	7 5%	2 5%	2 3%	3 6%
No response	11 7%	2 5%	4 6%	5 9%
PRIMARY PURPOSE OF HEALTH INSURANCE				
Full and comprehensive health care coverage	48 31%	15 39%	19 30%	14 26%
Generally full	27 17%	4 11%	13 21%	10 19%
Neutral	41 26%	11 29%	18 29%	12 22%
Generally catastrophic	10 6%	4 11%	3 5%	3 6%
Catastrophic and major events	22 14%	2 5%	7 11%	13 24%
No response	7 5%	2 5%	3 5%	2 4%

APPEAL OF DIFFERENT HEALTH CARE PLANS
BY MEETING SITE

Q111-116	TOTAL		MEETING SITE					
			Glasgow		Great Falls		Kalispell	
(n=)	155	100%	38	100%	63	100%	54	100%
PLAN A: UNIVERSAL COVERAGE, EMPLOYER PAID								
Great deal of appeal	33	21%	10	26%	12	19%	11	20%
Appealing	20	13%	6	16%	8	13%	6	11%
Neutral	20	13%	5	13%	8	13%	7	13%
Not appealing	13	8%	4	11%	6	10%	3	6%
No appeal at all	55	35%	8	21%	25	40%	22	41%
No response	14	9%	5	13%	4	6%	5	9%
PLAN B: UNIVERSAL COVERAGE, TAX PAID								
Great deal of appeal	7	5%	0	0%	3	5%	4	7%
Appealing	1	1%	0	0%	1	2%	0	0%
Neutral	8	5%	1	3%	5	8%	2	4%
Not appealing	12	8%	4	11%	5	8%	3	6%
No appeal at all	72	46%	4	11%	36	57%	32	59%
No response	55	35%	29	76%	13	21%	13	24%
PLAN C: UNIVERSAL COVERAGE, SELF PAID								
Great deal of appeal	6	4%	0	0%	2	3%	4	7%
Appealing	15	10%	9	24%	4	6%	2	4%
Neutral	21	14%	11	29%	5	8%	5	9%
Not appealing	14	9%	5	13%	6	10%	3	6%
No appeal at all	74	48%	7	18%	37	59%	30	56%
No response	25	16%	6	16%	9	14%	10	19%
PLAN D: STANDARD OFFERING BY EMPLOYER								
Great deal of appeal	19	12%	3	8%	9	14%	7	13%
Appealing	8	5%	2	5%	3	5%	3	6%
Neutral	21	14%	6	16%	7	11%	8	15%
Not appealing	14	9%	5	13%	3	5%	6	11%
No appeal at all	54	35%	7	18%	27	43%	20	37%
No response	39	25%	15	39%	14	22%	10	19%
PLAN E: SAVINGS ACCOUNT								
Great deal of appeal	22	14%	0	0%	12	19%	10	19%
Appealing	14	9%	2	5%	9	14%	3	6%
Neutral	22	14%	4	11%	10	16%	8	15%
Not appealing	8	5%	2	5%	1	2%	5	9%
No appeal at all	55	35%	6	16%	29	46%	20	37%
No response	34	22%	24	63%	2	3%	8	15%
UNDERSTAND REFORM PROCESS								
Very well	21	14%	3	8%	10	16%	8	15%
Fine	36	23%	7	18%	14	22%	15	28%
Neutral	35	23%	8	21%	14	22%	13	24%
Not well	17	11%	7	18%	8	13%	2	4%
Not at all	41	26%	12	32%	15	24%	14	26%
No response	5	3%	1	3%	2	3%	2	4%

MONTANA HEALTH CARE AUTHORITY

SUMMARY OF COMMENTS

TOWN MEETINGS

to discuss and receive comment on

UNIVERSAL ACCESS PLANS

JULY 19 – AUGUST 18
1994

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MONTANA HEALTH CARE AUTHORITY TOWN MEETINGS

INTRODUCTION

In the month between mid–July and mid–August, 1994, the Montana Health Care Authority conducted a series of ten "town meetings" in large and small towns across Montana, two in each of the Authority's five health care planning regions. The purpose of these meetings was to solicit public participation in developing two alternative health care reform plans for the state of Montana in order to ensure that they reflect the interests and concerns of Montana residents.

The locations, dates and attendance for each meeting are listed below:

Town	Date	Attendance
Great Falls	July 19	90
Malta	July 20	23
Wolf Point	July 26	27
Glendive	August 1	17
Polson	August 3	65
Missoula	August 5	145
Livingston	August 8	18
Butte	August 10	39
Lewistown	August 16	14
Billings	August 17	80
	Total:	518

The Authority sought four significant outcomes through the town meetings:

1. Participants should gain a better understanding of the problems, solutions and choices involved in developing comprehensive health care reform plans for the Montana legislature.

2. Participants will have an opportunity to discuss and provide feedback on two alternative plans for health care reform in Montana.

3. The strengths and weaknesses of each proposed alternative will be discussed and recorded for the public record.

4. Participant comments, concerns, suggestions and recommendations on key policy issues of health care reform, such as choice, cost and coverage, will be recorded and documented as part of the public record of the town meetings.

The first two outcomes are participant–centered. This brief summary focuses on the latter two anticipated outcomes and will present an organized and encapsulated look at recorded comment in the two areas: (1) health care reform issues in general, and (2) the advantages and disadvantages of each proposed reform plan. Comments were specifically solicited and recorded with regard to the two plans. Prior to any in-depth discussion of the two plans, participant groups were asked to prioritize their three most important questions about the entire reform process. A review of their most asked questions should provide a reasonably accurate illustration of the key policy issues of concern to the participants regarding health care reform in general.

At least one procedural caveat is important, however. The most reasonable way to bring more than a thousand comments into focus is by the process of categorization, or grouping similar comments together. Issues mentioned and comments offered more than once during the course of the ten meetings are listed here from most mentioned to least mentioned. Categorization is admittedly a somewhat subjective process and is decidedly more difficult when time and other resources do not allow for complete verbatim transcriptions of participant comments. Major themes did, however, emerge, and a diligent best effort was used to categorize the other comments. Every comment recorded at any of the ten meetings appears in Appendix C at the end of this report.

No diagnoses or prescriptions are presented here. The only purpose of this summary is to bring diffuse data into a somewhat more digestible form. Despite the fact that the town meetings were an ambitious undertaking, they are only one step in a public education and participation effort that has taken many steps and has several more to go. It is no accident that the Authority has solicited and received input from these town meetings which is very similar to that which it has responded to throughout the entire course of its work.

I. PARTICIPANT "QUESTIONS OF UNDERSTANDING" ABOUT HEALTH CARE REFORM

Introduction

The questions posed by the groups of participants in town meetings across the state addressed a wide variety of issues, but most fell within the three main components of the health care system: cost, access to care and quality of care. There were, however, a few other issues of concern which prompted questions.

Cost

The most questions on this issue inquired about what is being done to *determine the causes of rising costs*, and *control* them. Also, multiple questions were asked about "who pays for those who cannot?"

For the most part, however, questions in this area were more direct. Multiple questions were asked regarding "how much will all this cost? How will we pay for a new system? How will we pay for increased costs?"

Access

For the most part, participants did not ask questions which implied difficulty in gaining access to care. Several asked, "why are we talking about access? I have access. What I need is coverage." However, a small number of questions were received about the general issue of *rural access*. One such question was asked about guarantees of access in Malta. Another asked how competition would drive down costs in a rural area, where access is a critical need.

Concern about access to care for those with *pre–existing conditions* was also raised in a few instances.

Perhaps the most interesting questions in the area of access came from concerns about inappropriate access to the state health care system. Questions about *residency requirements* and *use of the system by out–of–state residents* were asked.

Quality of Care

Although many questions were asked about the continuation and/or inclusion of one specific benefit, the only benefit mentioned multiple times was in the general area of *preventive care*. Two other lines of questioning honed in on participant concerns about the loss of quality of care in the health reform debate. Multiple questions expressed concern about the general *impact of reform on the health care system status quo*. And more than a dozen questions were asked about the broad issue of *choice*. Questions were asked about two different types of choice: *choice of providers* and *choice of services and procedures*.

Other Issues

Other issues of interest where multiple questions resulted could be categorized in the following three areas: *government control*, *the "big picture"*, and *education*.

Government control was a concern, both generally and specifically. The general questions asked were of the traditional and skeptical variety regarding government's role in solving problems.

Other questions dealt more specifically with who would be controlling resources like facilities and services, and who would be determining what "usual and customary" meant.
Depending upon how all of the question asked are categorized, it can be said that more questions were asked about two "big picture" issues than about any other issues. The first issue inspired questions about the *interplay between state and federal reform efforts*. The second and related issue deals with the *effectiveness of Montana reform efforts in the absence of changes to health care programs already in existence*: Medicaid, Medicare, IHS, VA, CHAMPUS, Workers Compensation, ERISA, etc.

Education was the focus of another group of questions. Several focused on the need for, importance of or satisfaction with efforts at generally promoting *public education* regarding more efficient use of the system by consumers. One question specifically promoted the posting of provider prices as a way to enhance public education.

II. PARTICIPANT EVALUATION AND PERCEPTION OF THE TWO REFORM PLANS

Introduction

"Where you stand depends on where you sit." This old adage of public policy serves well to describe the varied responses received in comments about the strengths and weaknesses of the two reform plans drafted by the Authority.

The method utilized to display comments is similar to the method of listing verbatim comments in an analysis of survey research. Little embellishment on these descriptions is possible, as transcriptions of most of the comments made at the meeting were no longer than the phrases now used to categorize them. In addition, the categories sometimes represent the common element in comments which cover a broader range of issues, or more then one issue in a comment.

The Single Payer System – Strengths

Full coverage/Universal access – 28
Cuts administrative overhead – 21
Less confusing, simplicity – 11
Includes preventive emphasis – 8
More affordable – 8
Includes dental coverage – 8
Saves the state money/ cost containment – 7
Comprehensive benefits package – 5
Based on the ability to pay – 5
Covers pre–existing conditions – 4
Gets insurance companies "out" – 4
Portable – 3
Alternative providers covered – 3
Minimum benefits for all – 2
One source for payment – 2

The Single Payer System – Weaknesses

Too much government control – 31
High cost/high taxes – 27
Lack of choice – 19
No individual responsibility, incentive to healthy lifestyle – 11
Rationing, global budgeting – 9
Co–payments included or too high – 8
Danger of over–use of system – 7
Can't reduce costs without free market system – 7
No plan for cost control – 6
Would lose current good plan – 6
Not enough dental care – 3
No tort reform included – 3
No glasses, vision care – 3
Vague re: abortion coverage – 3
Out–of–staters participate at no cost – 2
Too drastic a change – 2

Like Canada's bad system – 2
Don't like HMOs – 2
Won't work with other programs (CHAMPUS) – 2
High out–of–pocket costs – 2

The Multiple Payer System – Strengths

More choice – 21
More competition – 13
Maintains the status quo – 12
Emphasis on preventive care – 9
Individual responsibility – 6
Saves the state money – 5
Coverage of pre–existing conditions – 5
Portability – 4
Comprehensive benefits package – 4
Universal coverage – 3
Subsidies a good idea – 3
Alternative providers included – 3
Easier done than the other one – 2
More creative programs – 2

The Multiple Payer System – Weaknesses

More expensive – 21
More state bureaucracy – 15
Individual mandate – 12
Community rating/increasing cost sharing in many communities – 8
High deductible – 8
Twelve month waiting period for pre–existing conditions – 7
No dental coverage – 7
No incentives for cost containment – 6
Harder to achieve universal coverage – 5
Co–insurance – 5
No tort reform – 4
Too complex – 3
No glasses, vision coverage – 3
Maintains the status quo – 3
No choice – 2
No public health component – 2
Durable medical equipment not included – 2
Hard impact on small business – 2

Comments Offered to Apply to Both Plans – Strengths

Portability of coverage – 4
Emphasis on preventive care – 2
Emphasis on education – 2
Begins to examine health care and costs – 2
Covers pre–existing conditions – 2

Comments Offered to Apply to Both Plans – Weaknesses

Won't work without federal waivers – 2
Both increase the role of government – 2

APPENDIX A
AGENDA AND GROUND RULES

AGENDA

- Welcome and opening remarks
- Explanations and instruction
  - purpose, outcomes, agenda
  - facilitation process, facilitators' role, ground rules
- Presentation of the two MHCA plans
- Open forum
- Tables report out
- Assessing the two plans
- Summarization
- Open questions and answers
- Evaluation and close

GROUND RULES

1. Everyone should be heard, so take turns.
2. Consensus is not necessary.
3. Respect the viewpoint of others.
   - Don't criticize them.
   - Don't try to convert them.
4. Respect the time limits.

APPENDIX B
COMMENTS ON TOWN MEETING PROCESS

The small group format was chosen to maximize interaction between participants and to establish a collaborative climate so that people feel heard, develop a sense of involvement in the process, and begin to own the results of the process. Small group interaction allows for more than one person to talk at once (if there are nine tables, then nine people can be talking at once). In addition, small groups tend to keep people's interest and therefore they are more likely to stay through the whole meeting. And the small group format also provides a structure that establishes coherence and minimizes distractions. It appears that the small group process succeeded in these goals with the following exceptions/modifications.

- Because the process makes it more difficult for extreme views to influence, dominate or intimidate, the members of organized factions tended to view the process negatively feeling it "controlled" them and that it was not representative of a real town meeting. Interestingly enough, however, those individuals not in organized factions but who also did not like the Authority's overall approach to health care reform nevertheless seemed to view the process positively.

- Those with moderate views tended to evaluate the process positively because it controlled organized factions and provided an opportunity for everyone to express their views. Overall, most participants left the meetings feeling they had an opportunity to express their perspectives.

- The format of the process was modified after the initial Great Falls meeting in response to strongly expressed views by many participants that there should be some time for individual questions/comments and that the Authority's presentation should focus more on the two plans and less on the Authority itself.

- Participants seemed to find value in being able to sit and talk with others about health care and in being exposed to others' views.

- Time was an issue for many participants but comments varied from complaints that the time was too long to comments that the time was too short.

- Other complaints heard repeatedly were that the town meetings really weren't open meetings because they only discussed the Authority's two plans; that there was only one Authority board member present; that there was a lack of adequate prior notification of meetings and explanation as to what the meetings were about; and that participants had no opportunity to review documents before the meeting.

- There was a general lament expressed that more people did not attend the meetings.

Observations

- Perhaps the "town meeting" designation was a misnomer for the actual process and raised expectations that were not met by a group approach, e.g., the opportunity to "debate" the issues.

- The group process did provide an educational experience for most participant which was one of the major outcomes identified by the Authority staff.

- For the most part, people stayed for the whole process with the exception of the Missoula meeting in which about one-fourth to one-third left in the last half-hour.

- În each location, the process took the full three hours with the exception of Livingston which ended at 9:45 p.m., perhaps due to the small number of participants (18).

- Some tables had problems with the facilitator role not being properly carried out.

- It should be kept in mind that at each meeting regional health care planning board members were present and that some attended more than one meting. Also, some individuals associated with organized factions also attended more than one meeting. Thus the evaluations and flip chart information may not truly be representative of a diverse group of citizens.

- Sam Hubbard, Authority executive director, and the Authority board member present at each meeting demonstrated a very good ability to respond non-defensively, forthrightly and with depth on questions and comments from the participants. It is felt that this ability has improved the overall image of the Authority as sincere in its attempt to solicit citizen input.

- The summarization at each meeting by the executive director and Authority board member seemed to be well received and may contribute to people feeling "heard" by the Authority.

- At the smaller meetings of 25 or fewer participants, one facilitator probably would have been sufficient. This refers to the meetings in Malta, Wolf Point, Glendive and Livingston.

- Health care reform is a complicated, complex issue which people seem to view from many different perspectives or dimensions, such as politically, economically, morally, socially (haves vs. have nots) and medically. As a result, some people come with a very limited view of what health care reform should look like while others hold a very broad perspective of what it should entail.

- Finally, it appears that there has been a good match between the purpose and outcomes developed for the meetings and the process and results from the meetings themselves. This is an indication of a good meeting design.

APPENDIX C

RECORDED INPUT FROM EACH TOWN MEETING

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
GREAT FALLS
July 19, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- o Will universal coverage be based on ability to pay? Not by forcing unaffordable rates on people
- o Who would determine quality of life, i.e. social standards?
- o How would Montana plan dovetail or conflict with a national plan?
- o Will there be limits to the number of services, visits, types of services available?
- o How can we gain emphasis on preventive care? Make preventive services mandatory? (more preventive services at cost?)
- o Where has all inflation in health costs come from? Can a source be pinpointed? (cost shifting, inclusion of other federally sponsored programs like IHS, Vets; technology; care crisis vs. insurance crisis; correct utilization of present system, i.e. E.R. vs. office visit)
- o Can we educate public in need for preventative care?
- o What limits on type of procedures: caps? rationing of health care?
- o What about coverage? We have access.
- o Is HAC investigating: what are causes of cost inflation? example, Medicaid?

Question #2

- o When has access been a problem? The problem is coverage not access. Access seems to be the wrong word. We have access but can we afford it?
- o How to improve quality and yet control costs?
- o What is the plan for non-physician providers?
- o Mandatory continuing training of doctors in developments in medicine? Going to set up review by peers of doctors' eases? Also hospitals?
- o Why not have posting prices all health care services and materials?
- o What educational system has been put in place or will be put in place to make utilization more cost efficient? (disclosure of insurance increases; insurers in multi-payer should be brought back into competitiveness by competition; reform--tort/insurance)
- o Clarify how we will measure outcomes and indicators of quality care: money's worth? doing right thing?
- o Why does government have to have full control over health care coverage?
- o Why are we spending time questioning authority's role when it's not open to change?
- o How will plan improve quality of care, improve access?

Question #3

- How are you going to educate people? (refers to last 2 goals)
- How are we going to implement preventive care?
- How is individual autonomy preserved in each of the H.C.A. plans?
- Catastrophic illness? pre-existing condition
- Rather than total reform have actions been taken to take more specific steps in tort and insurance?
- Unnecessary expenses have to be eliminated; change federal laws to allow people to let those go who have no chance of...
- What type of procedure, plan to be done--who decides?
- What will be done to address duplication of service--like two MRI's in one town?
- How can we put pressure on medical community to contain costs?

Other Questions/Comments

- How will whatever program fed comes up with affect the program Montana comes up with?
- What happens beyond legislature producing nothing? (if neither plan is approved)
- What is future of health care authority?
- How can we trust the health care authority when it is dominated by the industry it is empowered to reform?
- The open marketplace is the best tool for bringing about effectiveness, efficiency and economy. Why are we moving away from the marketplace?
- Affordable health care for all Montanans
- Access and availability
- Need for health care reform: increasing costs/cost shifting; large percentage without insurance; aging population; medicare/ medicaid reimbursement
- Explain personal health care database?
- Is there an expectation that the health care authority ideas will be heavily modified by legislation?
- Would the coverage that the H.C.A.. is proposing for us in Montana be just as good as national coverage?
- Will the plan accommodate for rural health care costs?
- Single state agency--how much control/input will public have on an on-going basis?
- Was economics the sole motivator for all this? Did they give consideration to needs for low-income, elderly and working poor?
- How are hospitals going to be monitored? including expensive medical equipment?
- *Going to limit number of visits and types of services in a year? Who's defining medically necessary services?
- Unnecessary duplication of medical equipment--will someone control this?
- "Counties medically underserved"--how many counties have large Native American populations?
- Are health insurance costs included in health care costs?
- *Different age groups have different needs--will it be administered equally/without discrimination? Limit services because of differences in age needs?
- Penalize people who have high risk characteristics?

o Medical problems/access/needs in rural vs. urban areas?
o How to get everyone to pay a share? ability/needs?
o High risk/high pools
o Coordination lacking/duplicative paperwork
o Limit on high end? don't pay above certain limit/don't pay below certain limit (income guide); limits (max) on certain services; price caps on routine services
o Who determines cut-off point and how? suggest doctor and patient?
o Malpractice?
o Access of care better distributed: what is equitable? assume responsibility of travel if located further out?
o Need jobs in the rural areas in order to provide health care there
o When people have no insurance and need care, cost shifting occurs
o Need to require everyone to have health insurance like car insurance
o Control administrative wastes to control total costs
o Negotiation with the tribes on IHS funding policy won't work: the tribe has always been on the losing end of government to government negotiation; the difference between cultural understanding and communication vary greatly; their medical coverage is minimal to inadequate
o How to get doctors to smaller towns?
o Will HAC be around after plans have been presented?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses

-speech therapy not covered
-if tax referendum passes, no financing mechanism!
-provider choice for HMO of pay-for-service should be the option of the patient who uses the service
-pulling the Fed. money into the state because military facilities are going to be allotted CHAMPUS funds for their "catchment area"--competition will result with state
-cost savings for people with high-price insurance payments--stop subsidizing other people's health costs
-monopoly
-can't see how we can reduce costs with removal of market incentive; need a level playing field; difference is to oversee the service rather than be the sole provider
-we feel the single payer plan won't contain costs as well
-each person should have to pay something
-no individual responsibility to own health
-means testing for poverty
-who selects physician
-cherry picking
-danger of overuse

-checks/balances

Strengths

-full range of coverage, preventative - long term?
-eliminates fear of losing health care or not getting it!
-everyone's covered
-appears to be based on ability to pay
-more affordable for consumers!
-appears to save state money
-P.T. and O.T. covered
-has option for HMO plan
-dental coverage
-what they re covering
-less paperwork
-no medical coverage under insurance plan
-cuts administrative overhead!
-guaranteed universal coverage
-reduce number of tests to cover doctor
-doctor chooses treatment with patient, no insurance gatekeeper!
-reduce frivolous claims!
-simplicity
-less bureaucracy
-better
-lower cost to better cost control
-for consumer who uses no deductibles, low co-payments

Regulated Multiple Payer System

Weaknesses

-12 month waiting periods
-more expensive to consumer and state
-2x for individual
-more administrative costs (new bureaucracy for state)
-speech therapy not covered
-durable medical goods not very well--everything costs more than $200
-care is prioritized "who decides what is medically necessary?"
-there are reforms that should either contain or reduce costs
-deductibles and co-payment are way too high
-mental health coverage is very poor
-where abortion coverage written into individual plans
-necessity of profits for components/adds to cost
-the multi-payer will be more difficult to make as inclusive--will cost more to maintain; will the state contract with an insurance company on SP plan?

-government regulation
-more increase in cost sharing in many communities
-it would cause some people to still become insurance poor
-too much paperwork (administrative costs)
-enforcement (legal?)
-how to insure affordable universal coverage

Strengths

-P.T. and O.T. covered
-appears to save state money
-based on individual responsibility
-more competition
-more creative programs
-mandatory enforcement
-change is hard, maintains status quo
-lower cost to taxpayer
-more responsibility for consumers

General Comments Made About Both Plans and Town Meetings

Weaknesses

-consensus/better format needed! for town meetings
-competition deleted from proposals
-consolidation medical components of other non-medical insurance packages, i.e., automobile insurance, work. comp, etc.
-no mention of MSA's (Medical Savings Accounts)
-(M.P.) insurance reform
-need a more open forum
-no public trust in government or insurance companies
-no coverage for reproductive freedom - need line item choice for this
-review board: elected
-costs still not definitely determined
-no mention made of assisted suicide
-where is the ability for flexibility? flexibility review benefits? review after a period of time?
-constraint: timeline short, need ability Montana shape own solution
-both systems: willingness to pay cost
-both rely on some federal dollars coming into state
-address coordination with worker's comp and other disability coverage?
-no pinpoint of actual cost
-subsidy
-government involvement in both plans
-giving away freedoms

-cost of implementing
-elimination of competition with single payer plan
-neither plan is adequate for uninsured now
-need more accurate statistics
-affordability
-limited medical care based on cost
-increases role of government in health care
-federal waivers
-cost controls (reductions) not addressed: free and open marketplace is best tool for controlling costs; both plans removed from free market forces

Strengths

-education regarding pros and cons of health care issues
-emphasized preventive care importance
-broad based needs fine-tuning
-review board: appointed
-started process before forced to accept federal plan
-government involvement in both plans
-universal coverage (both)
-portability
-competition among providers with multi-payer plan
-coverage for all
-portability
-begins to examine health care and costs

Questions Asked About Both Plans

-if a person is happy with current insurance, will they come out better with either plan?
-how can they offer all the benefits listed for the amount of money proposed?
-how can we get people off of Medicaid and welfare plans to cut costs to taxpayers?
-when will pro's and con's of each plan be publicly debated?
-what effect will set rates have on regional medical centers from state to state?

Comments About How Well Each Plan Meets Authority Goals

-goal #3: change to universal health care, get insurance out of picture
-goal #6: not met by either option
-we feel each plan is incomplete
-neither plan addresses goals
-neither plan provides for reproductive freedom choices
-both address growth in spending for health care
-not certain they avoid duplication of services, incl. health insurance administration in multiple payer plan

-promoting preventive care goal is being addressed
-educating consumers to be more responsible is being met
-single payer plan is better overall at meeting the goals--primary and preventive care
-single payer: can it really offer everything to everyone
-need for benefit options in both plans, especially for controversial issues
-fair/equitable way to determine coverage
-problem single payer--regulated how? would it be a public service authority type? public service commission - simple regulation; limited authority
-need more time to evaluate how plans meet goals--just seeing for the first time
-goal #1: no, maintain but not improve (discussion: caps, rationing, retention of physicians)
-goal #2: no, government involvement is synonymous with increased costs (discussion: if only 12% or 100,000 people are not insured why not just buy them a policy and bag the reform--new costs: 80,000,000/100,000 uninsured ooo/yr/person)
-goal #3: yes, done what was mandated
-goal #4: it has been addressed
-goal #5: not addressed fully
-goal #6: yes, town meeting good
-goal #7: yes, addressed
-goal #8: yes, but needs further pursuance
-goal #9: addressed but not solved (discussion: confusing insurance bills; not all are using single billing systems; bureaucracy not capable of simplifying system; complexity)
-goal #10: yes, data based collection is beginning (discussion: data not their business, invasion of privacy?)
-goal #4: there is a major concern about who is going to determine my right to life
-on a scale of 1 to 10 = 4.5
-cost could increase and quality would decrease
-in many areas, it is too early to tell
-there still appears to be many cracks and flaws in the systems
-there are too many "what if's"!
-access goal: yes, but doesn't get you there (i.e. coverage)
-goal #1: maintains but doesn't improve quality decreases others feel there's not enough information for assessment
-goal #2: may shift cost; will create better records; won't contain cost; if global budgeting costs will be contained
-goal #3: no, unsure, yes
-goal #4: no, how emphasize preventive care; how to get providers to small towns
-goal #5: yes and unclear

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
MALTA, MONTANA
JULY 20, 1994

Questions of Understanding

••Will there be a loss of a competitive market with a single payer system?
••How will state and federal plans fit together. Will states be forced to adopt federal plan?
••Are the minimum benefits listed all necessary? Are preventative services going to be included?
••Mistrust government ability to manage health care.
••Who pays deductible for those who can't
••Is everybody going to get the same care regardless of age and quality of life?
••How would things change under the multiple payer plan for those currently covered; would present benefits be reduced or watered down?
••If the goal is to control cost and insurance premiums, will rationing of health care result?
••How will you provide equal access and coverage of benefits in a remote are such as Malta?
••What incentives will there be for reducing health care costs, wellness programs, preventative medicine and rural distribution?
••Will there be choice of providers?
••Where does long term care fit into plan?
•Will there be a penalty for not having insurance under the multiple payer system?
•Canada's health care seems to be hurting. How will this be different?
•Will it cover 100% of prescriptions?
•How will the plans be financed?
•If you already have insurance will you then pay twice to finance health care?
•There does not appear to be incentives for competition.
•What happens to the insurance companies that are currently operating in the state?
•What about self employed people under the multiple payer system?
•What about pre-existing conditions?
•Who pays for lifestyles that risk high cost?
•What are the premium control mechanisms?
•Will and where will the system be reformed?
•How many are without health care by choice?
•Where is the money coming from?

Note: • denotes questions rated 1, 2 or 3 in importance

Assessing the Two Plans

Single Payer

Like:
- Less confusing
- Universal benefits
- Non cancelable
- Portability
- Covers pre-existing conditions

Don't Like:
- Too much government/central control
- Too much tax increase
- Unrealistic benefits resulting in rationing or global budgeting
- Loss of competitive market
- System will be over run
- Choices we be provided by the plan
- Cost to Montana citizens would be prohibitive
- Not compatible with rural areas

Multiple Payer

Like:
- More choices
- Portability and no exclusion because of pre-existing condition
- Consolidation of other government agencies
- Encourages competition
- Retains accountability
- Tax benefits available
- Present plans can be retained
- Restricted choices
- Multiple confusion
- No change from the present

Don't Like:
- Basic coverage is too extensive
- Where is the savings for those presently insured if taxes go up to insure the uninsured?
- How is cost shifting going to be addressed?

General Comments Applicable to Both Plans

- Question the need for any plan
- Caps on expenditures could equal rationing of health care
- Caps on charges lead to assembly line medicine
- Pre-existing condition clause is a plus
- Portability is a plus

•Want choices on doctors, insurance policies, coverage and health care
•Universal care offers no incentives to improve self
•Need tax incentives to reward good preventative care
•Need less government regulation
•Need tort reform

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
WOLF POINT
July 26, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- How is/are middle income individuals affected by multi-payor plan in payment of premiums?
- Is there an option to carry own insurance and, if so, do you still have to support the plan?
- Will we still be able to seek services out of state? (e.g. cross border into Williston, North Dakota?)
- What good is it to install without federal cooperation?

Question #2

- Why is there a "managed care" option under the single payer plan when competition has not yet proven to be cost effective?
- To what extent do we wish invasion of privacy through means testing?
- If vet programs, etc. are excluded, will those people still pay the taxes to cover others?
- Deductible--why difference?

Question #3

- a) Is there uniform billing for/from all providers? b) How are quality indicators going to be developed from existing data (i.e. cost containment discussion on provider profile and/or practice guidelines)? c) If you keep your existing health plan do you have to "contribute" to single/multi payor plan(s)?
- What choices (doctor, pharmacy, etc.) do we have? Have out-of-pocket expenses for each plan been compared?
- What will be the cost to administer the single payer system?
- How does the individual mandate work? (Try to control costs by encouraging capital expenditure by use of mobile services.)

Other Questions/Comments

- What will happen to all the insurance companies under the single plan?
- Are pre-existing conditions covered under both plans?
- Will this mean health care rationing?
- How will state plan tie into a national plan?
- Cost management/tort reform
- How much record keeping for providers?
- Is multi-payer $80 million new money?

o Why not analyze Blue Cross/Blue Shield which is nearly a single payer now?
o Healthy economy produces tax base--how to encourage?
o How can we institute single payer in small state? Prevent uninsured from other states from moving here?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses/Dislikes

-price/cost difference between fee for service and/or managed care
-tax supported
-never get through legislature; total government control, comparative administration cost unavailable
-loss of good insurance plan we already have
-doesn't feel it will contain costs as well as projected
-government control and centralization
-want to maintain choice of where to get service
-concern about social adjustment of change; getting from here to there without too much stress
-what if IHS, CHAMPUS, etc. say "no"?
-lose options for private plans
-government control of health care, tax cost, efficiency questionable, rationing of care, residency requirements lax, cannot anticipate cost without rationing

Strengths/Likes

-option of fee for service and/or managed care
-seems to address ability to pay
-TPA (BC/BS)
-taxed based on ability to pay
-administrative cost savings; more accessible to uninsured, simpler to understand
-simpler, less duplication
-minimum benefit for all
-benefit package comprehensive

Regulated Multiple Payer System

Weaknesses/Dislikes

-cost prohibitive to middle class
-pre-existing condition
-mandated coverage for individuals

-administrative costs
-higher administrative costs; more out-of-pocket expenses
-12 month exclusion
-50% co-insurance (but some co-pay is necessary)
-individual mandate
-income/subsidy--leaves out middle class

Strengths/Likes

-first dollar coverage for preventative primary care
-uniform benefit package
-more choices; closer to traditional model
-freedom to choose your own plan
-preventive services being provided
-minimal low cost plan
-freedom of choice
-preventive coverage

Questions

o How will you force people to pay??
o Will tort reform be enacted?

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
GLENDIVE, MONTANA
AUGUST 1, 1994

Questions of Understanding

First Priority Questions

•Does the Health Care Authority have the power to close, combine or approve expansion of private, medical entities?
•How will these plans be financed as far as those who cannot afford it. How will it be equitable for all?
•How do both the single and multiple payer plans address the 4 problem areas Sam mentioned in his talk? How does these two systems address quality and who sets the standard for quality?
•Does the subsidy of $80 to $90 million represent new taxes?

Second Priority Questions

•What is the definition of uninsured or underinsured with regard for access?
•What is driving the increase in overall health care costs between 1990 and 2000?
•When there is little cost connected with care, could that encourage over utilization. Will there be inappropriate use of facilities, e.g. emergency rooms?
•What if Medicare and Medicaid are lost through the Federal Health Care Reform plan?

Third Priority Questions

•How can you attain competition in rural areas?
•How can we address health care reform without including Medicare or Medicaid?
•How do you regulate out of pocket costs for low income people?
•How do you forsee the state and federal plans co-existing and meshing?

Other Questions

•Can small businesses afford either plan?
•How do you reduce paper work for efficiency?
•Will there still be insurance companies?
•What will happen to those who fall in the cracks in the Multiple Payer System?
•In the single payer plan is the cost and coverage the same for all? Does EMT pay more due to consumer index? Will it be regionalized?
•Multiple payer plan $1,000 per. will this actually help offer coverage?
•How does auto-medic pay coverage relate to this?
•What is meant by keep insurance competitive under multiple payer plan?
•If the plans make money, what will be done with the profit?

Assessing the Two Plans

Single Payer Plan

Like:
•Less paper work
•Universal care
•Payment from one source
•Good benefit package
•Less out of pocket expenses.
•The reimbursement process would be simpler because the customer would have only one organization to deal with.
•Everyone has the same coverage
•Dental coverage
•Optometric coverage
•Home care

Don't Like:
•High costs
•Less choice of doctors
•Not enough dental care
•Co-payment
•Will go broke in the long run because the benefits are so good and high utilization will result.
•Bureaucratic operations are less efficient than private operations.
•There may be less choice of providers.
•It is viewed as socialized medicine
•High cost
•No tort reform
•Out of pocket maximum is too high
•Payroll tax

Multiple Payer Plan

Like:
•Free Enterprise
•Greater Choice, e.g. HMO's and PPO's
•Gives customers more choice
•Comeptition may keep cost down as companies will seek more efficient way to operate.
•Primary care
•Home care

Don't Like
•No dentistry
•Higher co-payments
•Won't be affordable or equitable
•Plan is very complex and may be difficult to administrate.
•More expensive than single payer plan

•$80 to $90 million subsidy
•Payroll tax
•Coinsurance
•High deductible
•No dental

General Comments Applicable to Both Plans

•Will those who cannot afford to pay for coverage have to meet the deductibles
•It is goo that chiropractic care is covered.
•What happens to the people who fall in the cracks. There are people who can't afford insurance and neither plan says these people will be included.

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
POLSON
August 3, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- o Do we have to pay for coverage we don't want?
- o How will these Plans effect current in-place plans?
- o We need to have ways to benefit persons who take care of themselves (and don't utilize) as opposed to individuals who abuse themselves and the system--what can be done about it?
- o How is the multi-payer system different from what we have now? What is the big rush?
- o Who are the health care providers who can provide service? (e.g.. are alternative care providers included such as naturopaths, nurse practitioners, physical therapists, etc.)
- o What are we going to do about cost shifting?
- o In what ways are you planning to reduce costs by reducing paperwork and billing problems?

Question #2

- o What about the retired and self-employed? and employee/employer pay? (i.e. you don't have an employer)
- o What's the tax impact to the individual Montanan on the single payer system?
- o Of the 12-16% of Montanans who choose not to be insured, how many are medically uninsured?
- o What about the interference between federal and state regulations? Will Federal government let us do it our way?
- o In the requirement for length of residency of plans, what happens to current existing policy?
- o What is the State's track record for running similar systems such as Medicaid/Work Comp?
- o Will the single payer plan eliminate need for MA, C Medicare, IA, etc. or is it another government plan we have to deal with?

Question #3

- o Is there an age limit for coverage?
- o Where do the premium prices come from?
- o What about the other problems besides without insurance that have effected this "problem" regarding tort, regulations?
- o What guarantee that your projections are what it will really cost?
- o How to equate the single payer with fee for service?
- o Are we going to look at provider profile (what is the outcome and what is the cost)?
- o Who decides what is medically necessary and fixes the price for different procedures?

Other Questions/Comments

- o Can we go to the doctor (etc.) of our choice?
- o What does "subsidy" mean? Who gets paid the subsidy directly?
- o How much will it cost the average family? (above 200% above poverty?)
- o What happens when Montana runs out of money? for year?
- o Is this supposed to save money?
- o How much are people paying now?
- o Aren't we being forced to pay for [others] services? (e.g. we don't want/will never use abortion, drug and alcohol counseling)
- o Are premiums fixed? Is there coverage for naturopaths?
- o What does enforcement mean?
- o Are we spinning our wheels because Federal will tell us what we have to do?
- o How will these plans relate to any federal agenda?
- o What is the current cost of health care in Montana?
- o What other options to insurance, i.e. self-insured
- o Need more details on business shouldering responsibility
- o Why wait to address long term care?
- o Could we go to a doctor of our choice when out-of-state?
- o Where does the state of Montana get the idea they have the authority to run a health care system?
- o Isn't single payer the ultimate in cost shifting?
- o Is the only difference in plans the source of revenue and how administered and benefits?
- o How often do you get waivers (MC federal, ERISA) and if you don't get waivers, what does it do to the plan?
- o How will tort reform be accomplished?
- o Explain further the health resource management plan.
- o What is safety net for low income, above poverty level for payments?
- o What is the cost % age considering for malpractice? [*note: exactly as written*]
- o What is driving the cost of health care?
- o What is the mechanism to pay for reform?
- o How do we measure quality if we're using cost as a criteria?
- o If we are going to ration care, how are we going to do it? age? transplants? disability? family history/genetics?
- o How will coverage for pre-existing conditions affect cost?
- o If there is universal coverage, will there be a penalty for those who do not want it?
- o Are we going to end up paying more for less?
- o What is the relationship of the State Health Care Plan to the Federal Plan?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses/Dislikes

- o too much government control

o glasses not provided for other than children
o global budget
o increase taxes
o no confidence in government management
o more taxes to implement
o government controls
o lack of choice
o impact to small employer
o forced to accept (versus keeping own plan)
o community rating
o more costly
o abuse of system regarding fraud by providers
o over-utilization of services
o without incentives for cost containment
o government administration can lead to abuses, more bureaucracy
o interferes with present insurance coverage
o lack of individual choice
o have to pay for whole package whether you need or want it
o government run system
o not within jurisdictional role of government; government has no business in this
o unclear as to whether abortion would or could be covered
o covers alcohol and drug abuse as disease
o assumption that one plan fits all
o lack of choice in HMO
o government control
o scrapping finest system
o regulations inability to access utilization and control information
o rationing
o government control
o costly--no incentive to consumer to contain cost
o loss of free market
o no incentive to utilize least costly avenues
o resent same fee for service if Health Life Step(?)
o state program has poor track record
o very little individual control
o no incentive to live healthy lifestyle
o doesn't guarantee local access of health services--mail order, etc.
o one tiered system
o no safeguards against out of state people collecting benefits without contributing to tax pool

Strengths/Likes

o cost cheaper for individual regarding deductibles
o idea of reform of health care
o alternative providers covered

o lower total cost
o one form - one method of billing
o takes care of catastrophic situations for those that "fall between the cracks" with needs that exceed insurance
o 100% coverage
o preventive care emphasis
o simplicity
o fewer co-pays and less coinsurance percentage than multi-payer
o does away with pre-existing conditions
o comprehensive universal coverage
o low deductible for families with low income--makes care more accessible
o reduced administrative costs, if true
o dental coverage
o simplicity of administration
o one plan for everyone
o consumer education regarding the system--"predictability"
o gives government a handle on cost control
o it will guarantee coverage to everyone especially the 12-16% not now covered
o portability and irrevocability
o one tiered system

Regulated Multiple Payer System

Weaknesses/Dislikes

o regulation
o complex
o no glasses at all
o global budgeting
o don't mess with so much
o insurance company reimbursement procedures
o lack of confidentiality
o community rating
o refer to previous page [*note: these were the dislikes listed under single payer that they refer to--more costly, abuse of system regarding fraud by providers, over-utilization of services, without incentives for cost containment, government administration can lead to abuses and more bureaucracy*]
o redundant
o unclear as to whether abortion would or could be covered
o max out of pocket seems high--we will still see cost shifting
o covers drug and alcohol abuse as disease
o individual responsibility
o high deductible prevents access for some people
o doesn't solve cost shifting because so many required/??designed programs i.e. Medicare
o limit of 12 months for pre-existing illness

o no enforcement mechanism (weakness?)
o weakness: subsidies need to go higher for families/some singles
o seems similar to current situation, still unequal access for certain groups
o modified community rating doesn't provide incentives
o loss of small self-employed providers
o still does not address cost shifting and integration of other systems
o tort reform not addressed so no cost control
o standardizing forms, billing, payers
o haven't asked people that knew the systems best--hospitals, pharmacists, professionals
o too much corporate bureaucracy
o no incentive to stay healthy
o doesn't guarantee local access to health care needs--mail order, etc.
o doesn't cover dental in minimum package

Strengths/Likes

o cheaper for state
o (mis)abuse should be less because deductible is higher?
o more choice/freedom
o free market competition
o choice
o projected costs
o comprehensive universal coverage
o does away with pre-existing condition
o individual responsibility
o can choose level of coverage
o private sector and higher quality of care
o easier to fix what's wrong with existing--not redo entire system
o have coverage for pre-existing and genetics
o market competition
o personal service versus government controlled service thus more incentive for quality
o innovation for development of plans
o level playing field
o summary: MP is preferred plan because don't have to redo whole system; provides coverage for pre-existing and genetic; allows innovations for developing plans and incentives for quality
o more individual control over the types of medical care they want to pay for
o portability and irrevocability
o ability to choose deductibles and ind. plan
o you choose your own doctor, hospital, drugstore

General Comments Made About Both Plans

Weaknesses/Dislikes

o lack of preventive and "staying well" focus
o amount of high coverage for substance abuse coverage

Strengths/Likes

o move towards cost containment, access to care
o more consumer access for information

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
MISSOULA, MONTANA
AUGUST 5, 1994

Questions of Understanding

First Priority Questions

- Has the Montana Health Care Authority been considering current cost cutting measures being approached by providers?
- How will reform be paid for and how large will the bureaucracy be for governing?
- Why is there cost sharing in the single payer plan?
- How are working people going to be able to afford high cost of multipayer plan and what are the penalties for not having insurance?
- How does the creation of a single payer system fit in with state government mandate to reduce spending?
- Why create individual mandate which allows people to slip through cracks rather than ensure universal coverage?
- What happens to those individuals who have pre-existing conditions and have no insurance now? What about individuals with pre-existing conditions if insurance lapses?
- What are the differences in benefits between the single payer and the multiple payer?
- How would providers be determined under the single payer system?
- How will fixed income folks and low income folks afford premiums/copayments?
- Has individual mandate been tried elsewhere?
- What incentives are there for employers to continue to cover employees?
- If people have individual mandate, why would employers provide coverage and wouldn't employers back out?
- Why are the benefit packages so different under the two plans?
- How can we make more effective use of c0-pay and co insurance to provide incentives for cost containment?
- What do we do if businesses are not able to afford these plans. Will there be employee cutbacks?
- With the single payer plan, what happens to the insurance companies that are not selected as the administrator?
- Are there licensed providers paid for in both plans?
- What impact will federal plan have on the state plan?

Second Priority Questions

- When grand fathering in current federal programs, how will they control cost shifting?
- Why is HMO included in single payer?
- Why is Blue Cross Blue Shield favored in the plan?
- If no premium caps what to prevent insurance companies from raising premiums especially to cover people with pre-existing conditions?
- How does Medicare and Medicaid fit into this?
- Why high deductible and copayment? Why 12 month exclusion? What affect will single payer have on providers?
- How do the disabled pay for premiums under both plans?
- Does the board see a difference between a tax or mandatory insurance premium?
- What about women's health issues such as reproductive rights and mammography's as well as general preventative treatments: Are they included?
- What is the incentive for employers who provide coverage now to maintain it?
- Why isn't there a consumer advocate on the Health Care Authority?
- Why are the benefit packages so different under the two plans?
- How will these plans be financed?
- How do we deal with the fact that some people that have the funds choose not to have insurance and there are others who can't afford it
- How do they determine what these costs are?
- Will education for people with chronic diseases such as diabetes be paid for in services of nurses and dietitians?
- Why waiting period on pre-existing conditions?

Third Priority Questions

- Expand on statements concerning current costs versus projections for costs for plans
- Need clarification on budget caps
- Why not question the source of exorbitant medical care costs?
- Do the financing and provider options correlate between both plans?
- Will there be another tax to cover the costs?
- Why is dentistry not an equal part of the plan?
- How much of the premiums will go for administration as compared to benefits?
- What is the plan for transition?
- Pre-existing conditions and disabilities. these plans discriminate. How to provide equality.
- Why are the benefit packages so different under the two plans?
- Will these plans do away with present health care
- If I don't have insurance under the individual mandate, will I go to jail or ER. and who pays hospital?
- How will duplication of services, especially capital expenditures be controlled?
- Can I seek out my own doctor? Is there any fine or penalty for doing so?
- What happens to people who are already insured and have better benefits when the new plan goes into effect?

Other Questions

- Why cap outpatient services but not inpatient services when outpatient services might be less expensive?
- What options the authority didn't consider because of legislative limitations?
- Do we want intervention in health care?
- Do we want to control the medical profession?
- What is fee for service in single payer plan
- Is this plan mandating everyone to have insurance?
- What is selective contracting
- What is the rate of increase in the costs of plans
- If no insurance and can't pay, what happens?
- Are they going to make physicians go to rural areas? How do we get doctors to rural areas?
- Will a new bureaucracy be created and how much will it cost?
- How would federal health reform affect state current laws and proposed laws?
- Why is it going to cost so much more to have employer paying insurance?
- What about the US. Prevention Task Force?
- What is this private company they will contract with and how much will they make?
- What happens when you don't have an employer?
- Overall costs for single payer and multiple payer are not on the same basis. Comparing the numbers doesn't make sense
- Will employers opt out?
- How will low income people afford?
- Why doesn't home care include LTC?
- What is the overall benefit if modify system?
- What about those who chose to be uninsured?
- How do we pay for it?
- How is the state going to select an administrator?
- What is the definition of a family and a couple?
- How will the state enforce the individual mandate?
- What is the role of the employer?
- How is size of family addressed in regards to low income?
- What about consumer choice?
- Why are health care costs increasing so fast?
- Why is there a 12 month waiting period on pre-existing conditions if they will get insured an anyway?
- What proportion of the population is under insured?
- What percentage of rising health costs are attributed to law suits and malpractice issues?
- Are other legitimate health care providers such as podiatrists and naturopaths included in the two plans?
- What does the word recommended mean on page 9 of the draft plans?
- What specifically does preventative include?
- How will those on fixed incomes and low incomes afford premiums and copayments?
- What about tort reform?
- How will all this work with congress?
- What is included in preventative care?
- How will these plans prevent the abuse of health care systems in the US.?
- What about cost sharing when some employers pay employee premiums and others do not?
- What about tort reform?
- In multipayer system what are the different premiums. Based on age?
- What will be better than the veterans health system?
- How about a junk food tax?
- If happy with private insurance, can I keep my present scale of benefits or will I lose benefits?

• Are naturopathic and other licensed primary care professionals covered under single payer plan?
• Is the cost of premiums going to go down?
• Are multipayer benefits less because of administrative costs?
• Will insurance companies make money off of individual mandate?
• What will happen if we exceed our global budget?
• Where do the statistics come from?
• Is there any thinking about some sort of merged plan as an alternative to these two?
• What percent of people that get hospital care don't pay their bills?
• Have you looked at fixing the current plan?
• How can we be assured that actuarial estimates are accurate?
• Prevention, where does it come in. Didn't hear anything in the discussion about preventative care.
• Have cost containment measures been examined. Medical providers, pharmaceutical companies?
• Is either plan proposed by the Authority the regional alliance as defined by the Clinton proposal?
• Why isn't dental covered on multipayer?
• Hospice, home care and skilled nursing. would that create a sub bureaucracy?
• What happens to specialists with expanded use of mid level providers?
• What if I move to another state?
• Does the electronic data bases violate doctor patient traditional confidentiality?
•$24,000 limit. If employer paying insurance and employees is below poverty levels, does the state pay for the insurance?
• Will treatment of biological mental health disease be paid for in both plans in the same way that treatment for other disease is paid for?
•Why is there a 12 month pre-existing condition clause when you first sign up?
•Why was mental health limited to 30 days for inpatient and 60 days non residential?
• How will this promote competition and price control?
• How were estimates of costs derived?
• What will be the employer incentive to find low cost plans?
• Will there be any subsidies for the deductible coinsurance for low income?
• What limitations will be placed on individuals and insurance companies?

Assessing the Two Plans

Single Payer Plan

Like:

- Good coverage for all
- Simplified and cuts out insurance costs
- Expanded to other licensed health care practitioners
- Easier to facilitate universal coverage
- Cost savings
- Consumer and provider choice
- Based on ability to pay
- Global budgeting and forecasting
- Operates according to costs, not cost plus profit
- Simple to operate and administer-Costs less
- No free market
- Less expensive and provides more benefits
- Like the simplicity of having one plan
- Less Administrative costs
- Less cracks for people to fall through
- Addresses dental costs
- Deductible is less
- Provides preventative practices
- Prescriptions paid and covered as primary care physicians
- Includes everybody
- No insurance companies
- Administrator
- Universal coverage
- Guaranteed coverage
- Doctor's rather than insurance companies will determine care
- Includes dental care
- No pre-existing conditions
- No profit margin
- Simple
- Preventative care without copay
- Thoughtfully put together
- Cheaper to run
- Lower deductible
- Eliminate controls and costs
- More fair to employees, employers, etc.
- Saves money
- Eliminates insurance companies and administrative costs
- Provides universal coverage
- Doctors instead of insurance companies can decide what care is needed
- Better dental care
- Overall savings
- Don't have to buy coverage
- More cost controls
- Same coverage for all
- Includes dental
- More fair financing
- Would help small businesses
- The nation needs a model
- Variety of benefits, coverage is good

- Choice of MD/provider will be protected if single payer is done right
- Chance of capturing everyone
- Simplicity
- Government involvement
- More people covered
- Comprehensive
- Co pay and individual responsibility
- Accessibility to health care
- Emphasis on prevention
- Mental health coverage
- Good concept
- Keep copayment/deductible with strong subsidies
- Portability
- Uniform benefit
- Choice of coverage

Don't Like

- Don't like HMO and single payer together
- More choice in the single payer plan-no HMO
- Removes market choice and incentive
- Don't like deductibles and copays
- Global Budgeting
- No control of cost
- Not a true single payer system because there are deductibles and copayments
- $5.00 per prescription encourages drug used
- Costs the individual more than the multiple payer plan
- Fear the government will not be able to manage it.
- Fear of rationing
- Fear the federal government will exert limitations/rationing
- Where is the coverage to educate people about responsibility and preventative care?
- Too expensive
- Does not address unequal coverage of individual states. Will one become overburdened by ill immigrants?
- Doesn't include vision care for adults
- Eliminates competition
- Limits on nutritional coverage
- Additional paper shuffling
- This is not the Canadian system
- HMO
- Low income means discriminatory treatment
- No control of cost
- Government is involved
- No public health component
- No incentive for going to get care: responsibility rights
- No tort reform
- 20% too high on copayments
- Preventative measures are not clear and specified-mammography for example
- Reproductive rights are unclear
- Dental care not covered for adults except in emergencies
- Expensive premiums
- Tort reform not addressed
- HMO's don't belong
- There should be no copayments and deductibles
- Inability of a business to control costs

- Taxes
- Large bureaucracy
- Limitations of access
- More cost controls
- Possible rationing
- True single payer plan would have no copayment or deductible
- How can it control costs
- Single payer copays will not control costs
- Missing preventative dental care for adults: not cost effective or healthy
- Omitted adult vision coverage
- 6 month residency is discriminatory
- Regulatory bodies must have consumers including uninsured and under insured.
- Higher costs
- No freedom of choice
- No individual responsibility
- Government should not run our health care
- Where is serious liability reform?
- Does not address abortion funding
- Difficulty with cost control
- Focuses more on services for young rather than elderly
- Potential inefficiency of government bureaucracy
- Home infusion not provided for
- Exclusion of self insured and Indian health
- Co insurance
- Hospice and homecare not an alternative to inpatient
- Eliminate HMO

Multiple Payer Plan

Like:

- Allows market forces to work
- More entities will be contributing than in the single payer
- Expanded to other licensed practitioners
- Subsidies
- Free market
- Choice of health care providers
- Provides impetus for seeking alternative services
- More self responsibility for health care choices
- Costs
- Gives consumer more incentive to shop
- Will make choices more carefully
- Fairer to individuals. Individual costs will be the same no matter their income
- Provides preventative practices
- Out of packet maximum = $6,000 per family for catastrophic illness
- Guaranteed issue and renewable
- Primary and preventative have no deductible
- Competition
- Subsidy
- Preventative care without copay
- Thoughtfully put together
- Choices
- No deductible on primary care
- Covers alternative providers
- Less bureaucracy
- Government involvement
- Portability
- Eliminates pre-existing conditions
- Preventative awareness
- Minimum change
- Better cost
- Emphasis on prevention
- Mental health coverage
- Age bands, community ratings
- Possibly more efficient and cost effective
- Per diem coverage for hospice care without layer coverage
- Coverage extent

Don't Like

- Don't like individual mandate
- If you have controlled competition in multiple payer it is more complicated/too complicated and more expensive.
- Don't like employer mandates
- No choice
- Believe its discriminatory
- No reform, its status quo
- High Cost
- No ability to guarantee universal coverage
- High deductibles
- Disadvantage with retrospective review of conditions
- How to trust people making pre authorization on rental equipment
- That everyone has to be covered
- Pocket of healthy people who do not use the system and do not want to have to be covered

- Too expensive
- Large deductible
- Pre-existing conditions
- Employer responsibility
- How will this be enforced
- Not universal
- Cost ceilings on specialized care such as physical therapy
- Does not pay for durable medical equipment
- Limitations of benefits
- Disabled can't go to work without losing coverage or no coverage for pre-existing conditions resulting in continued need for state support of income, healthcare, food, housing, etc. Can't break out of the system and lead a normal life.
- Accidents not covered. If long term and catastrophic illness. No cushion between cancel and to S.S.
- Government involved
- Community rating, bonds
- Too many cracks for people to fall through
- Payer mandates not enforceable
- Competition not a controlling factor
- No public health component
- No incentives
- Perpetuates status quo
- Tax dollars subsidizes private insurance companies
- No cost controls
- No tort reform
- More difficult to access health care
- Discriminatory
- Too expensive
- Deductible is way too high
- Doesn't guarantee cost control
- Employers are let off the hook and employees absorb everything
- More bureaucracy
- Increase deductible
- Does not respond to tort issues
- Cost containment of doctors and drugs
- No choice of doctors
- Is being enforced on US. by special interest groups
- Omission of adult dental coverage
- Women's issues not addressed
- Maintenance issues not addressed
- Coverage deemed sufficient is not sufficient
- What about public health care
- Required of every individual
- Different age group premiums
- Insufficient rehabilitative services
- Covers alternative providers-the concern is about letting any provider do anything.
- Incentive for businesses to drop coverage
- More bureaucracy
- Durable medical equipment not included in out of pocket
- Copayment too high
- Payment would increase from current payment.
- Poor people forced to buy package will only get a bareboned package
- There should be no waiting period for pre-existing conditions

- Will continue our present managed care cutthroat competition and we don't have enough people to support it.
- We need our privacy
- Examining ER. use retrospectively for appropriate use will be an administrative nightmare.
- No way to enforce that present employer money for insurance will go to the employee when they stop paying insurance
- Individual mandates will be a nightmare for hospitals, etc., and will force still cost shifting and more administrative costs
- Mistake to omit adult vision coverage
- No room for profit /administrative costs under multipayer plan
- Won't control costs
- Missing adult preventative dental care
- No government involvement
- Are costs real?
- Where is liability reform
- Does not address abortion
- How to enforce individual mandate?
- Home infusion not addressed
- Band aid approach to health care reform
- Inclusion of insurance companies
- Individual mandate

General Comments Applicable to Both Plans

- Need to be introduced gradually
- Need higher copay for emergency
- What happens if don't get federal waivers
- Both address preexisting, portability, simplified application
- Need much clearer delineation of where funding will come from-costs vs. current money in place.
- Unsure about the whole thing
- Concerned about people who fall through the cracks
- Concern about low income people-how will they pay the deductible
- Physical therapy limitations per calendar year-$2M
- What happens to person who gives up better plan/coverage?
- Will there be a fee schedule for services by health professionals? Should fees be the same in Billings as Missoula or Havre?
- Actual data doesn't distinguish between legitimate need and lack of self responsibility.
- Plan just covers Montana not everyone else like other countries.
- Include dental care for everyone
- A plan available to pay what one can afford to pay
- Like that we have a state to go through this exercise.
- Both plans lean toward institutionalization
- Open forum is too controlled. Only asks for criticism and comments on plans presented by the authority. Should allow for improvements on draft plans?
- Where is Dorothy, et. al.
- Individual mandate plan supports hybrids if bureaucrats that can keep much information secret.
- If you really wanted to know what we think, you would give each of us a piece of paper.
- Is health care authority trying to maintain the status quo. Is the real name of the authority the Society for the Protection of the Status Quo?
- Likes government regulation
- Medicare has too much paper work. Would these plans be better?
- Private sector would do the administration better.
- 300 private insurers operate in Montana. they should have a single claim form.
- The health care authority addressing other needed areas to keep health costs down and even reduce it.
- Need changes in civil bankruptcy laws so that no medical expenses can be used in bankruptcy.
- Doctor and Professional liability limiting or capping on allowing no malpractice suits.
- We do not like that adult dental care is not included in multipayer plan and is very limited on single payer plan
- We would like to see that all the people that need it have access to it but others can choose not to be covered.
- I don't like it because I don't have a choice.
- Better access to prevention
- Why do I have to go on a state plan that will provide me less benefits but will cost me more?
- Will there be a cap on taxes as well as expenditures?

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
LIVINGSTON
August 8, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- Expand and clarify those that will not be covered initially, such as the working poor. Have those uninsured initially been included in cost estimates?
- Under single payer plan, what happens to private insurance plans? What happens to Medicare/Medicaid funds if single payer plan adopted?
- Is there a simplification of insurance red tape (e.g. paperwork, etc.)?
- On Medicare--would we be forced into a different system?

Question #2

- How will state Medicare fit with national changes? Single payer--will Medicare supplements be available?
- Six month waiting period for people coming into Montana vs. 12 months for pre-existing conditions--this is confusing?
- Why was not tort reform dealt with up front as a serious issue?
- On multipayer plan--who pays for uninsured? State?

Question #3

- Can a well-provided-for person go outside the state plan for health care?
- Define with clarification why this plan would be better than the one we have.
- On multipayer plan--how do you enforce requirement to have coverage? what about illegal aliens?

Other Questions/Comments

- What is meaning of pre-existing conditions? Under multiple payer plan, the State may be left with only "poor risk" people; others will be in existing insurance plans.
- How does global budgeting differ from caps on costs?
- On single payer system--can you change between FFS and HMO? how often?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses/Dislikes

o change too drastic
o government regulation
o legislation and regulation takes health care decisions away from consumer and provider
o enforcement difficult
o not addressing true health care reform--discussion is dollars not health care reform
o co-insurance and co-pay for primary and preventive package
o dislike misuse of the system
o where is the individual responsibility (*building incentives into the system)
o don't like having someone else running the system (expand); are we creating choice?
o can we afford it!
o taxes too high
o no cost containment

Strengths/Likes

o simplicity
o potential
o appropriate government activity to guarantee basic health care to all citizens
o more simple
o everyone is covered
o simplicity
o enforcement by regular taxation method

Regulated Multiple Payer System

Weaknesses/Dislikes

o not addressing true health care reform--discussion is dollars not health care reform
o enforcement difficult
o out of pocket maximum is overly restrictive and expensive--$6,000 a family
o self serving limits on outpatient physical therapy/rehabilitation too low (2000)--what is included?
o increased number will move into subsidized group due to high co-pays/deductibles
o too confusing
o will not likely lower cost
o dislike the multiplicity of forms
o difficulty in enforcement of requirement for coverage

Strengths/Likes

- o uses what we have
- o provides more choices and freedom
- o more likely to retain Medicare than single payer
- o offers more choice
- o like more choice
- o more honest
- o would be better managed (cost containment)

General Comments Made About Both Plans

Weaknesses/Dislikes

- o neither plan addresses limits on outrageous medical procedures

Strengths/Likes

- o both plans address primary and preventive health care; we like multiple-payer benefits best

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
BUTTE
August 10, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- What happens to Medicare and Medicaid, private insurance, CHAMPUS, V.A., Union Insurance coverage?
- What happens to Medicare? Will they come under family or two-person pay?
- What about those with good coverage now that are happy with their coverage?
- How will we pay for plans? what percentage increase of income tax?
- How will a tax funded medical delivery system compare with the current premium based system? (Person over age 65--will it cost more than current Medicare and Medicare supplement premiums?)
- What improvement over present system as far as access?

Question #2

- How are they (the government) going to mandate this?
- Under both plans, who will determine what charges are usual and customary? (What about services not offered in state of Montana?)
- Under single payer, how is it possible for market forces to be used as a cost containment mechanism?
- How will HMOs be formed?
- How will we pay for increased medical services in the 28 medically deprived counties?
- How will services be restricted to contain costs?

Question #3

- When does the whole state get covered and who has the authority, e.g. federal vs. state?
- How much difference would multiple plan make in solving the current problems?
- Will the federal plan overrule state plan?
- Will gambling be taxed for health care?
- Great concern for loss of choice! Difference between the current free market system and government influenced program!
- What options will self-insured companies have?

Other Questions/Comments

- How often will the policy change?
- Who bears the expense--"Everyone pays fair share"?
- How does Hawaii get coverage to individuals?

o What's the 12-month pre-existing condition?
o Does single payer plan lend itself to limiting existing enforcement plans?
o Will either of the two plans create new taxes and how much new government will that make?
o How will physician choice be affected?
o Long term care?
o Has Hawaiian plan been considered?
o Will individuals be covered while outside Montana?
o Surtax--What will sin taxes increase by?
o Will single payer plan include state employees?
o Is this our only choice? i.e. single payer-multiple payer
o Is it feasible to assess more taxes? Will we hurt our business economy?
o Where will money come from precisely to pay for each plan?
o Do we have to choose either plan?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses/Dislikes

o no competition--higher cost?
o co-pay necessary
o how is abuse/overuse controlled?
o want the same program that the federal government, congress and senators have
o more government control--it hasn't worked for Canada, how will it work for us
o it amounts to complete overhaul; concentrate on 12% only
o problem of government control of procedures (experimental); who approves?
o lacks efficiency incentives that exist in the competitive marketplace
o choice of only one plan
o loss of out-of-area coverage
o all painted with one brush--lose retirement benefits
o pre-existing clause
o taxes
o too high of out-of-pocket premiums
o 30% of population would be excluded due to the fact they belong to a non-regulated employer plan
o lose freedom of choice; more government!
o no choice but to have coverage
o cost more in long run due to increased bureaucracy
o too drastic of a change

Strengths/Likes

o the leverage it would have in cost containment
o the $200 deductible in single payer as opposed to the $1,000
o like it--reduced administration cost
o everyone covered
o administrative efficiency
o less paperwork
o distributes money for medical services evenly
o sliding scale idea
o total coverage
o same care for everyone
o cost less in long run
o administered by private company

Regulated Multiple Payer System

Weaknesses/Dislikes

o co-pay necessary
o want the same program that the federal government, congress and senators have
o out-of-pocket costs for individual too high
o profit (insurance companies) driven
o deductibles too high, also co-pay
o individual mandate not enforceable

Strengths/Likes

o might be cheaper--less costly
o keep private insurance if want to
o sliding scale covers working poor
o more freedom of choice
o prefer multiple payer with reforms
o less government
o competition - no monopoly
o portability
o regulation of the insurance companies
o companies can opt out
o flexibility
o universal coverage
o choice/variety
o easier transition

General Comments Made About Both Plans

Weaknesses/Dislikes

o it's pretty hard to comment when you don't have time to look everything over
o both plans don't address cost containment
o skilled nursing care is only 100 days

Strengths/Likes

o both plans do a good job on preventive and primary health care

Questions/Comments

o How this will fit into Indian Health Services and how much input have they had?
o like universal plan
o like Hawaiian plan
o portability critically needed
o preventive care is of primary importance
o expanded mental health benefits needed
o How are we going to care for chronically mentally ill?
o fix what's broke, not total overhaul

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
LEWISTOWN
August 16, 1994

OPEN FORUM - QUESTIONS OF UNDERSTANDING

Question #1

- What are the coverage differences in the two plans?
- Who regulates the regulators?
- Could cost containment be implemented with the system we now have?

Question #2

- Would someone address the issue of the criticism that either or both plans would create another Workmen's Comp problem (mess)?
- Where were the graphs, data and information generated and how is the cost being calculated?
- What will be the impact on existing smooth running plans?

Question #3

- What penalty would be imposed in the multipayer plan for individuals who do not insure?
- What are the co-payments?
- Did the Authority give us the option of no change?

Other Questions/Comments

- Which plan has the most extensive benefits and provides the most benefits for the money?
- Is it correct that either plan would cost $900 million?
- Why do they always consider deductibles and not co-pays?
- Does the 12-month exclusion on pre-existing conditions mean just one or more than one?
- Do all Canadian provinces have a single payer plan? Why? (We've heard only one province began that way.)
- What can be done to relate cost of plan to administrative cost?
- Multipayer--what is the coverage for home care, long term, nursing home?
- Could some of the things in the cost containment (pp.17-18) be done now?
- Did the Authority address less socialized approaches through business incentives?

ASSESSING THE TWO PLANS

Single Payer System

Weaknesses/Dislikes

- o government's responsibility and accountability for management
- o Why can't we have same kind of management in government that we have in private industry?
- o expense makes it almost politically impossible
- o comparisons with Canadian system's history
- o high cost
- o government control; no private incentive to be competitive
- o don't like socialized government bureaucracy
- o don't like that single payer eliminates present system and income taxes would double
- o doesn't preserve quality

Strengths/Likes

- o low cost
- o universal coverage
- o simplicity
- o easier to administer
- o more efficient
- o eliminates cost of administrative costs, such as paperwork
- o "the way to go"--it will save time and be more efficient
- o comprehensiveness of coverage
- o 95% coverage
- o better records and data base on cost
- o dental coverage
- o best ultimate plan with good coverage and could be funded with employer mandate and co-payments

Regulated Multiple Payer System

Weaknesses/Dislikes

- o high deductibles
- o can't force people to take insurance
- o simply expands the current Medicaid system
- o too much book work and administration
- o 12-month pre-existing
- o also government involvement
- o removes personal (poverty level incomes) fiscal responsibility
- o would double my cost of insurance

o will increase the cost to taxpayers
o seems like a double tax: payroll and income tax
o emphasis is on regulation rather than incentives

Strengths/Likes

o universal coverage
o personal choice--flexibility of choosing insurance provider
o fairly comprehensive minimal coverage
o requires residency
o people with insurance don't have to change
o would preserve present union systems which are generally good problems
o everyone required to have insurance
o requires business to provide the opportunity to get insurance

General Comments Made About Both Plans

Weaknesses/Dislikes

o cost still picked up for non-insured; however, it does not require government involvement
o not portable (*could be changed by simple requirement no new break)

Strengths/Likes

o current market
o pressure is lowering health cost

Questions/Comments

o DO NOT ADOPT EITHER PLAN.
o still need tort reform
o can we give reasons why we are doing this
o want to see the third alternative of no change
o part of the push for insurance is the push to equalize the system
o fear of the cost and increased bureaucracy

MONTANA HEALTH CARE AUTHORITY TOWN MEETING
BILLINGS, MONTANA
AUGUST 17, 1994

Questions of Understanding

First Priority Questions

- What happens concerning pre-existing conditions and 12 month wait?
- Are there other plans that will be considered?
- Any alternatives to financing?
- For the multipayer system, would there be an individual mandate and an increase in taxes?
- 25% of health care in Billings is to out of state people. How will that be handled?
- How will required coverage be enforced? What penalties are there if you choose not to be insured?
- If a mandate is placed on health insurance, will costs go up like care insurance? How can you enforce it?
- In multiple payer plan, what is protection for afford ability? What are costs? Clarify costs for out of pocket expenses? How will costs be limited over time?
- Are there any limitation to additional alternative programs?

Second Priority Questions

- How will you force people to have insurance coverage?
- How will you enforce the individual mandate?
- How do plans effect disabled on Medicare and Medicaid?
- Will federal and state employees be exempt?
- How long to study tort reform?
- How long to study long term care?
- How do premium caps and global budgeting occur without resulting in rationing?
- What is the financial incentive to keep healthy?
- How many Montanans out of 100,000 can afford health insurance but spend money elsewhere?
- How will you mandate payments when some will not be able to pay or won't pay?
- Have you looked at program similar to federal employees program, i.e. contract for program?

Third Priority Questions

- HMO's which plan? What about people's choice?
- How much does the federal plan affect Montana's plan?
- Are there any alternative plans?
- How will the federal plan combine with the state plan?
- Where was inflationary cost projection obtained?
- How are we going to contain the cost?
- What method is used to contain costs?
- Which plan allows choice of provider?
- Can you choose your own doctor and pay your own bill?
- How do you compare costs for an individual between the single payer and multiple payer?
- Clarification on Medicare: Is there a deduction taken out for Medicare in the Multiple Payer Plan. Is Medicare included?
- What are various business incentives going to cost state in lost revenue?
- How much can state save if 47% payout of Workers Compensation (illness) is paid by state health plan?

Other Questions

- What is an example of preventative care?
- What is the maximum life benefit in the multiple payer plan?
- What is the benefit or advantage of community rating?
- Modified work reentry
- What percentage of current costs is from cost shifting?
- Is supplemental insurance affected?
- What are the effects of an increasing number of senior citizens on increasing costs?
- Why is supplemental insurance excluded?
- Does alternative care include nutrition, naturopathic care, or chiropractic care
- Is chronic disease treatment covered?
- How much cost shifting is taking place and would everyone paying reduce the total?
- What is the difference between the proposed health care reform and socialized medicine?
- What is comprehensive coverage?
- What if you have no insurance in multiple pay system?
- What happens if national insurance legislation is passed/
- Are non traditional services covered?
- Do we need to wait on the federal plan?
- Will the plan hurt Billings as a medical center?
- What happens to the plans if CI 66 or 67 pass?
- If you are self employed, who pays the premium?
- What happens to alternative medicine?
- If the multiple payer system is selected, will there be an increase in state bureaucracy?
- How can we contain costs of insurance companies and premiums?
- What is the enforcement mechanism?
- How is freedom of choice protected?
- How will state and federal plans merge?
- How does state plan to enforce multiple payer alternative?
- What happens to the Medicare budget and/or proposed cuts?

Assessing the Two Plans

Single Payer Plan

Like:

- Everyone is covered
- Maintains cost
- Deductibles lower
- Administrative efficiency
- Out of pocket maximum is less
- Medicare (all one) better
- Can afford to access health care system
- No insurance companies
- Equal access to health care
- No charge for preventative care
- Covers everyone
- Aiming for healthy society
- More effective cost control
- Direct billing with one provider
- Cuts red tape
- Covers prescriptions
- All people are covered
- Easy management
- Universal coverage
- Administered by someone other than the state
- Single claim form
- Covers alternative and preventative care
- Universality
- Choice of doctors needs high cost sharing
- Private entity will administer process
- Focus on preventative and basic services

Don't Like:

- HMO's-need choice
- Federal mandates
- High cost in taxes
- Possible rationing
- Government will run health care
- Benefits are too rich
- Discourages individual responsibility
- Cost of plan
- Way to fund as it is stated
- Lack of individual responsibility
- Government control
- Government involvement always increases cost over what is done in the private sector. More taxes and control. Why not competition and limits on lawyers
- Global budget rationing
- Loss of research and development
- Technology rationing
- At the mercy of the government
- Why should they buy our coal if the severance tax doubles
- Costly-high taxes
- No competition
- Gets away from the spirit of "privatization"

- Limited choice
- Tax increase
- No HMO
- Co pay and deductible-not a true single payer system
- Cost increase
- Fear that state will take over
- Too expensive
- Cuts out free enterprise
- Too complex

Neutral Comments/Questions

- What does Rush say about this?
- What administers this plan and how is that decided?

Multiple Payer Plan

Like:

- Choice and less government
- Cost sharing equals more individual responsibility
- Continuing to use existing systems
- Can be fee for service
- Coverage for disabled, etc.
- More individual responsibility
- Lower costs
- Requires less change
- Preventative services
- Regulates insurance companies
- Less expensive to individuals
- Less cost through competition
- Responds to demands of market place and retains best parts of our system
- Promotes competition
- Covers alternative and preventative care
- More freedom of choice
- Free enterprise, competitive

Don't Like

- Co payment of 50% high
- Out of pocket is high
- Forced coverage
- No changes in present infrastructure
- No changes in medical costs
- Amend federal tax codes
- Community rating
- Low cost plan is too expensive
- Not sure how disabled will be included
- Individual mandates are bizarre
- Ob/gyn component
- Some won't have coverage
- Some will have inadequate coverage
- Low income has to spend a large percentage of income on health care
- Lack of potential for monitoring insurance carriers
- No provision for dental
- Doesn't eliminate cost shifting
- Not as good of coverage
- Doesn't address supplemental programs and how to integrate these
- Double wham to wage earners and employers
- Could put small businesses out of business
- System tends to undo the principle of the survival of the fittest
- Individual mandate (forced coverage)
- More expensive to business
- High cost of deductible and co-insurance
- Soft approach to cost containment
- Global budgeting
- Costly-high deductible
- Some people may opt out but if they get sick, costs will still be passed on
- Individual mandate
- Increase in bureaucracy
- Bare bones coverage

- Cost increase like car insurance
- State appears to be insuring income to insurance companies
- Problem with 12 month wait for pre existing conditions
- Lack of dental and vision care
- Problem with record keeping
- Concern about any deductible resulting in lack of preventative or early treatment and care
- Too expensive

General Comments Applicable to Both Plans

- What incentives are there for individuals to lead healthier lives, e.g. rate cuts for non smokers?
- What about migrants, transients and people passing through. Who pays for their medical care?
- Neither plan addresses problems of universality, access, cost containment, long term health care needs.
- Fundamental questions are not adequately dealt with
- Concern that chosen plan will fall through and uninsurable will be left out
- What happens if neither plan passes the legislature?
- No significant cost saving in either one
- More free enterprise solutions such as project '94 -heal Montana

MONTANA HEALTH CARE AUTHORITY

TELEPHONE SURVEY

FINAL REPORT

AUGUST 1994

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MONTANA HEALTH CARE AUTHORITY TELEPHONE SURVEY FINAL REPORT

INTRODUCTION

This report summarizes the procedures and findings of a telephone survey conducted for the Montana Health Care Authority. The purpose of the survey was to determine attitudes of Montana residents toward many different components of health care reform. The survey consisted of 411interviews with adult residents of Montana completed between July 9 and July 13, 1994.

METHODOLOGY

The survey was conducted with the six station Computer Assisted Telephone Interviewing Laboratory at Montana State University, Billings. The random digit dialing sample was purchased from Survey Sampling, Inc. The numbers in the sample are representative of the distribution of households with telephones. In order to complete 411 interviews, 2,718 telephone calls were made to 2,012 telephone numbers.

Upon the completion of the survey, the data was electronically transferred to the VAX computer system at Montana State University, Billings. The computer program Statistical Package for the Social Sciences (SPSS) was used to analyze the data. The results have a margin of error of $\pm 5\%$.

FINDINGS

The Respondents

Table One summarizes the demographic characteristics of the respondents. Table One shows the respondents were approximately half male and half female. The mean age of the respondents was 46.5. About 16% of the respondents were between 18 and 30, nearly 50% were between 31 and 50, and 8.4% of the respondents were over 70.

About one third of the respondents lived in households which consisted of two parents and children while another 24.7% lived in a household consisting of a couple who had grown children away from home. Fourteen percent of the respondents were single with no children and 12.1% lived in households consisting of a couple with no children.

Nearly 44% of the respondents worked full time for an employer, 20.7% were retired, 14.9% were self employed, and 11.1% were employed part-time. Thirty one percent of the respondents who were employed worked in the public sector, 21.5% were employed in small businesses, 14.5% were employed in agriculture or natural resource related positions, 13.1% were employed in health care or insurance and 11.6% indicated that they were employed in other private businesses.

Twenty-eight percent of the respondents working in the private sector were employed by employers with between six and 25 employees while 23% worked for employers employing five or less employees, 20.3% worked for employers who had more than 100 employers, 16% worked for organizations with 26 to 100 employees and 12.3% of the respondents working in the private sector worked alone.

TABLE ONE - DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Sex

Male	202	50.5%
Female	198	49.5%

Age

18-30	65	16.5%
31-40	90	22.8%
41-50	89	25.6%
51-60	65	16.5%
61-70	52	13.2%
Over 70	33	8.4%

Mean Age = 46.5

Household Composition

Single, No Children	56	14.1%
Couple, No Children	48	12.1%
Single, Children Home	28	7.1%
Couple, Children Home	133	33.5%
Single, Grown Children	29	7.3%
Couple, Grown Children	98	24.7%
Other	5	1.3%

Employment Status

Full Time	173	43.7%
Part Time	44	11.1%
Self Employed	59	14.9%
Not Working	22	5.6%
Retired	82	20.7%
Other	16	4.0%

Type of Employer

Public Sector	85	30.9%
Agric/Nat Resource	40	14.5%
Health Care	36	13.1%
Small Business	59	21.5%
Other Private	32	11.6%
Other	23	8.4%

Employer Size

Work Alone	23	12.3%
Less than 5	43	23.0%
6-25	53	28.3%
26-100	30	16.0%
More than 100	38	20.3%

The respondents were asked a number of questions about their health insurance, health, and medical history. Table Two summarizes the results of these questions. Table Two shows that 30.3% of the respondents reported they had health insurance that they partially paid for. Twenty-one percent of the respondents indicated they paid for all of their health insurance while 17.2% reported their insurance was totally paid for by their employer. Twelve percent of the respondents indicated that they were covered by Medicare and 8.3% of the respondents said they were uninsured.

The respondents with insurance were asked to evaluate their coverage using a one-to-five scale where 1 is poor, 2 is fair, 3 was average, 4 is good and 5 is excellent. The most common answer was good and this answer was given by 35.8% while the second most common answer was excellent (24.2%). On this 1-to-5 scale the mean score was 3.6.

Eighty-five percent of the respondents with insurance indicated that neither they nor any member of their household had been denied insurance for health reasons. Eleven percent of the respondents with insurance said they had been without health insurance within the last three years and another 9.4% said that a member of their household had been without insurance in the last three years. When the number of currently uninsured respondents are added to these respondents, a total of 108 respondents (26.3% of the total number of respondents) lived in households in which one or more members were without health insurance in the last three years.

TABLE TWO
INSURANCE AND MEDICAL STATUS

Health Insurance Status

Not Insured	33	8.3%
Entirely Self Paid	83	21.0%
Partially Self Paid	120	30.3%
Entirely Employer Paid	68	17.2%
Medicare	48	12.1%
Medicaid	7	1.8%
Other	37	9.3%

Rating of Coverage

Poor	21	5.9%
Fair	43	12.1%
Average	78	22.0%
Good	127	35.8%
Excellent	86	24.2%

Mean Rating on 1 to 5 Scale = 3.6

Coverage Ever Denied for Health Reasons

Yes-Self	33	8.0%
Yes-Other in House	25	6.4%
No	335	85.2%

Without Insurance During Last Three Years

Yes-Self	41	11.4%
Yes-Other in House	34	9.4%
No	286	79.2%

Note: This Table Does Not Include Those Who Indicated They Were Currently Not Insured

Received Emergency Room Care In Last Three Years

Yes-Self	100	25.3%
Yes-Other in House	108	27.3%
No	187	47.3%

Received Outpatient Surgery In Last Three Years

Yes-Self	76	19.3%
Yes-Other in House	58	14.8%
No	259	65.9%

Over Night Hospitalization In Last Three Years

Yes-Self	85	21.5%
Yes-Other in House	59	14.9%
No	251	63.5%

Have a Personal Doctor

Yes	291	72.8%
No	94	23.5%

Received Care From Naturopathic Doctor In Last Three Years

Yes-Self	8	2.0%
Yes-Other in House	5	1.3%
No	380	96.7%

Received Care From Chiropractor In Last Three years

Yes-Self	30	7.6%
Yes-Other in House	28	6.8%
No	338	85.4%

Received Care From Public Health or School Nurse During Last Three Years

Yes-Self	12	3.0%
Yes-Other in House	27	6.8%
No	356	90.1%

One-quarter of the respondents reported they had received emergency room care within the last three years and another 27.3% reported that someone in their household had received emergency room care in the last three years. Nineteen percent said they

had undergone outpatient surgery within the last three years while another 14.8% said that someone in their household had undergone outpatient surgery in the last three years.

Twenty one percent of the respondents indicated they had spent a night in the hospital in the last three years while another 14.9% said that a member of their household had spent a night in the hospital in the last three years. Seventy-three percent of the respondents indicated they had a personal doctor. Ninety-seven percent of the respondents indicated that neither they nor a member of their household had received care from a naturopathic physician in the last three years. Eighty five percent of the respondents indicated that neither they nor any member of their household had received care from a chiropractor in the last three years, and 90.1% of the respondents said neither they nor any member of their household had received care from either a school nurse or a public health nurse.

Perceptions of Health Care and Health Care Reform

First the respondents were asked what magnitude of change they thought was necessary for the health care system. Table Three presents these answers as well as answers to additional questions dealing with changes in the health care system. Seventeen percent of the respondents believed the health care system should undergo a fundamental overhaul, nearly 38% of the respondents believed that major changes were necessary, and 36.2% thought minor changes were necessary. Only 9.2% did not believe any changes were necessary in health care.

The respondents who believed that some type of change was necessary were then asked, in an open-ended format, to identify the most important change needed in the health care system. Table Three shows that slightly more than half the respondents who believed change was necessary believed the most important change was to lower the cost of health care and make it more affordable. The second most common change mentioned was to make coverage available to more or different people. The majority of these respondents mentioned universal coverage, but some respondents mentioned bringing coverage to certain type of people, most commonly, the elderly. Other changes mentioned by many fewer respondents were to regulate the insurance business, to provide better care, to have less governmental involvement and control, to eliminate pre-existing condition clauses, to bring more and better care to rural areas, to eliminate fraud and abuse, to limit the amount of bureaucracy and paper work, and to limit and reform malpractice awards.

Next the respondents were presented with a series of goals for health care reform and asked to rate each one of the goals on a scale of 0-to-10 where zero indicates not important at all and 10 indicates very important. In Table Three, the ordering of these goals is based on the mean score on this 0-to-10 scale. Reducing waste was rated most important as a goal of health care reform by the respondents with a mean score of 8.63. Reducing cost increases was rated the next most important followed by reducing the cost of prescription drugs, emphasizing preventative care, reducing the number of malpractice suits, providing universal coverage, providing coverage between jobs, and improving health care quality.

The respondents were asked to identify the most important goal of health care reform and presented with the same list. Paradoxically, the most common answer to this question was to provide universal coverage (26%). The second most common answer was to reduce waste, followed by reducing cost increases, reducing the cost of

prescription, to reduce malpractice cases, to improve quality, and to provide coverage between jobs.

The respondents were asked who would be the best designer of the health care system and by far the most common answer was a combination of governments and the current health care industry. Very few respondents believed that either the state or federal government would be the best designer of the health care system.

Nearly three-quarters of the respondents believed that health care changes should be undertaken gradually.

TABLE THREE
PERCEPTIONS OF HEALTH CARE CHANGE

Extent of Change Needed

Fundamental Overhaul	63	17.0%
Major	139	37.6%
Minor	134	36.2%
None	34	9.2%

Major Type of Change Needed

Cost/Affordability	136	51.7%
Universal/More Coverage	81	30.8%
Regulate Insurance	17	6.5%
Better Care	7	2.7%
Less Government Control	4	1.5%
No Pre-Existing Conditions	4	1.5%
Rural Care Improvement	4	1.5%
Eliminate Fraud/Abuse	4	1.5%
Eliminate Bureaucracy	3	1.1%
Malpractice Reform	3	1.1%

Goals of Change

	0 to 4	5	6 - 10	N	Mean
Reduce Waste	3.7%	7.4%	88.9%	404	8.63
Reduce Cost Increases	5.9%	9.0%	85.1%	409	8.30
Reduce Prescript Costs	6.4%	11.6%	82.0%	406	8.16
Preventative Care	6.2%	12.8%	81.0%	406	8.08
Reduce Malpract Suits	6.7%	14.5%	78.9%	400	7.94
Coverage For All	20.5%	11.1%	68.4%	395	7.17
Coverage Bet. Jobs	12.1%	18.3%	69.8%	398	7.16
Improve Quality	18.8%	18.8%	62.4%	404	6.88

Most Important Goal

Guarantee Coverage	106	26.0%
Reduce Waste	93	22.8%
Reduce Cost Incr.	61	15.0%
Reduce Precript Cost	36	8.8%
Reduce Malpract	32	7.8%
Preventative Care	29	7.1%
Improve Quality	23	5.6%
Other	21	5.1%
Between Jobs Coverage	7	1.7%

Best Designer of System

Combination	280	73.9%
Current Industry	75	19.8%
State Government	15	4.0%
Federal Government	9	2.4%

Should Change Be Rapid or Gradual

Rapid	104	26.0%
Gradual	296	74.0%

Next the respondents were asked to evaluate a number of different health care reform ideas. They were asked to indicate whether they disliked the idea very much, disliked the idea, felt neutral about the idea, liked the idea, or liked the idea very much. Table Four presents the results of this evaluation. The ordering of items in Table Four is provided by the mean score for each item on a 1 to 5 scale where 1 is dislike very much and 5 is like very much. For ease of presentation, dislike very much was combined with dislike while like very much was combined with like in Table Four.

Table Four shows the health care reform idea liked the most by the respondents was limiting insurance premiums which received a mean score of 4.18. The next most popular idea was to regulate hospital fees (4.06) and then to limit physician fees (3.94). Of the seven general ideas the respondents were asked to evaluate, only two were rated as less than 3.0. These two ideas, making individuals responsible for obtaining and paying for health care and requiring that employers pay for more than half of their employees' health insurance premiums, received a mean rating of 2.98, just barely below neutral.

TABLE FOUR
RATING OF GENERAL HEALTH CARE IDEAS

	Dislike	Neutral	Like	N	Mean
Limit Prem Increase	8.2%	4.0%	87.8%	402	4.18
Regulate Hosp Fees	11.1%	9.3%	79.6%	407	4.06
Regulate Dr. Fees	13.9%	11.5%	74.2%	403	3.94
Require Coverage	36.8%	15.3%	47.9%	399	3.10
Employers Respons.	37.5%	17.2%	45.3%	408	3.08
Individuals Respons.	40.0%	22.1%	38.0%	403	2.98
Employers Pay More	40.4%	16.9%	42.7%	403	2.98

The respondents were also asked to rate four general health care proposals. For this evaluation, respondents were asked to use a 0-to-10 scale where zero indicates a bad idea and 10 indicates a good idea. Table Five summarizes the results of these ratings. As Table Five shows, the most popular proposal was that health insurance could not be canceled for any reason except failure to pay. The second most popular proposal was that coverage would be maintained between jobs. The third most popular proposal and one that was evaluated almost equally to the second most popular was eliminating the pre-existing condition clause as a reason for denying insurance. The least popular of these four proposals was choosing a health care plan from among all the plans provided in the state rather than having a plan dictated by employers. Even this least popular plan received a mean rating of 7.91 on the 0-to-10 scale.

TABLE FIVE
RATING OF SOME GENERAL HEALTH CARE PROPOSALS

	0 to 4	5	6-10	N	Mean
No Cancellation	3.4%	6.1%	90.4%	409	8.95
Between Jobs	6.2%	7.9%	86.0%	406	8.45
No Pre-exist Cond.	7.3%	6.6%	86.2%	411	8.44
Choose Plans From List	10.9%	11.4%	77.6%	402	7.91

In order to understand some of the respondents' concerns about health care reform, the respondents were asked how they thought taxes, costs of health care, security of health care coverage, choice of providers, benefits, and quality of health care would change if health care reform were enacted. Table Six summarizes the answers to these questions. The ordering of items in Table Six is based upon the percentage of respondents who believed the item would go up a lot.

As Table Six shows, 46.6% of the respondents believed taxes would go up a lot under health care reform. One-quarter of the respondents thought that the costs of health care would go up a lot if health care reform were enacted while 13.5% thought security of health care coverage would go up a lot. On the other hand, nearly twenty percent of the respondents believed that choice of providers and quality of health care would go down a lot under health care reform as they understood health care reform.

TABLE SIX
PERCEPTION OF CHANGES UNDER HEALTH CARE REFORM

	Down-Lot	Down Little	Same	Up Little	Up-Lot	N
Taxes	.5%	2.0%	7.6%	43.3%	46.6%	395
Costs	1.3%	21.3%	16.3%	36.0%	25.2%	381
Security	7.4%	15.6%	24.3%	39.3%	13.5%	379
Provider Choice	19.2%	33.5%	24.7%	17.1%	5.5%	385
Benefits	12.9%	34.2%	18.9%	29.2%	4.7%	380
Quality	19.4%	30.5%	22.9%	22.6%	4.6%	371

In order to better understand the respondents perceptions of changes under health care reform, the respondents were asked how they felt these same six items would change if health care reform did not take place. Table Seven summarizes the results of this series of questions.

Taken together, Tables Six and Seven show that more of the respondents believed that each of the items would stay the same if reform were not enacted than if it were. Generally respondents believed that costs would go up more if health care reform did not take place, that taxes would go up more if health care reform did take place, and security would be more likely to decrease if health care reform did not take place. More respondents believed that quality would decrease if health care reform did take place than if reform were not undertaken. More respondents believed that provider choice would go down if reform were undertaken than if reform did not take place. More respondents felt that benefits would go up if health care reform did take place than if it did not.

TABLE SEVEN
PERCEPTION OF CHANGES IF HEALTH CARE SYSTEM DOES NOT CHANGE

	Down-Lot	Down Little	Same	Up Little	Up-Lot	N
Costs	2.0%	3.8%	13.1%	52.6%	28.5%	397
Taxes	1.3%	4.1%	27.0%	51.7%	16.0%	393
Provider Choice	3.6%	17.0%	58.2%	15.5%	5.7%	388
Quality	8.1%	21.8%	48.9%	15.9%	5.3%	395
Benefits	11.3%	33.0%	41.2%	10.2%	4.3%	391
Security	16.5%	31.0%	39.6%	9.4%	3.4%	381

The respondents were asked which component of health care has the most influence on how the health care system works. The answers to this question are summarized in Table Eight. Table Eight shows that nearly half the respondents believed insurance companies exert the most influence on health care followed by the federal government (15.2%) and then hospitals (14.9%).

TABLE EIGHT
WHICH HEALTH CARE SYSTEM COMPONENT INFLUENCES HEALTH CARE THE MOST

Insurance Companies	173	49.7%
Federal Government	53	15.2%
Hospitals	52	14.9%
Physicians	29	8.3%
Other	25	7.2%
State Government	16	4.6%

The respondents were then asked how much a number of different health care system components contribute to the overall cost of health care. In assessing the contribution of each of these components, the respondents were asked to use a 0-to-10 scale where zero indicates the item contributes nothing to the overall cost of health care while 10 indicates the item contributes a great deal. Table Nine summarizes the respondents assessment of the relative contribution of health care system components to the overall cost of health care.

Table Nine shows that hospital charges were thought to contribute the most to overall health care costs (mean = 8.25) followed by insurance companies (8.07), malpractice suits (7.65), an aging population (7.60), administrative costs (7.58), new technology

(7.53), doctor's fees (7.30), inappropriate use of the health care system (7.28), prescription drugs (7.04), long term care (6.89), lifestyle choices (6.83) and increased violence in society (6.68).

TABLE NINE
PERCEPTION OF CONTRIBUTION TO OVERALL HEALTH CARE COSTS OF DIFFERENT HEALTH CARE COMPONENTS

	0 to 4	5	6-10	N	Mean
Hospital Charges	3.5%	8.1%	93.4%	405	8.25
Insurance Companies	5.7%	9.9%	84.4%	405	8.07
Malpractice Suits	10.2%	13.7%	76.1%	393	7.65
Aging Population	7.2%	13.7%	79.1%	401	7.60
Administrative Costs	9.2%	11.4%	79.5%	404	7.58
New Technology	7.0%	16.3%	76.7%	399	7.53
Doctor's Fees	8.9%	16.6%	74.4%	403	7.30
Inappropriate Use	14.8%	11.5%	73.7%	399	7.28
Prescription Drugs	12.1%	16.5%	71.4%	405	7.04
Long Term Care	12.6%	18.5%	68.9%	389	6.89
Lifestyle Choices	11.0%	22.5%	66.5%	400	6.83
Increased Violence	21.1%	12.5%	66.4%	399	6.68

One of the primary purposes of this survey was to find out what benefits respondents want in a standard universal package of benefits. To determine this, the respondents were presented with a list of twenty-one possible benefits and asked if each one should definitely not be included, probably not be included, probably be included or definitely be included. Table Ten summarizes the respondents beliefs about including these benefits in a standard policy. The order of items in Table Ten is based on a mean rating for each item on a 1-to-4 scale where 1 meant the item should definitely not be included, 2 meant it should probably not be included, 3 meant it should probably be included and 4 meant it should definitely be included.

Table Ten shows that surgery, emergency care, preventative care, prescription drugs, abortion to save the life of the mother, doctor visits, hospice care, dental care for children, medical rehabilitation services, abortion for pregnancy resulting from rape or incest, and mental health care all had a mean rating of 3.0 or more, where 3.0 indicated probably include. On a scale such as this, 2.5 is the point which separates a mean closer to inclusion from a mean closer to exclusion. Only three items, care from naturopathic doctor, abortion services, and acupuncture, received a mean score of less than 2.5.

TABLE TEN
INCLUDE IN STANDARD POLICY

	Def Not	Prob Not	Probably	Definitely	N	Mean
Surgery	1.8%	2.8%	29.5%	65.9%	393	3.59
Emergency Care	2.0%	5.0%	38.8%	54.3%	400	3.45
Preventative Care	3.8%	5.8%	47.9%	42.6%	397	3.29
Prescription Drugs	1.8%	7.6%	51.3%	39.3%	394	3.28
Abort/Mother's Life	8.9%	5.2%	37.8%	48.0%	381	3.25
Doctor's Visits	2.8%	10.9%	50.6%	35.6%	393	3.19
Hospice Care	5.4%	12.5%	44.1%	38.0%	392	3.15

Dental Care-Children	5.5%	16.3%	38.7%	39.4%	398	3.12
Medical Rehab	3.3%	11.6%	55.3%	29.8%	389	3.11
Abort/Rape-Incest	10.9%	8.8%	38.3%	42.0%	376	3.11
Mental Health Care	4.7%	18.5%	48.8%	28.0%	379	3.00
PA & NP Visits	6.3%	19.0%	47.4%	27.3%	384	2.96
Eye Care	8.8%	21.0%	42.4%	27.8%	396	2.89
Dental Care	8.6%	21.8%	43.0%	26.6%	395	2.88
Hearing Care	8.7%	26.0%	42.2%	23.1%	389	2.80
Family Planning	18.3%	16.7%	37.8%	27.2%	389	2.74
Substance Abuse	11.2%	27.9%	40.7%	20.2%	376	2.70
Abort/Option	24.5%	17.5%	39.7%	18.3%	355	2.52
Naturopathic Care	29.8%	38.6%	24.5%	7.2%	376	2.09
Abortion Services	41.3%	22.3%	24.5%	12.0%	368	2.07
Acupuncture	36.9%	40.2%	18.9%	4.0%	371	1.90

The respondents were presented with a list of six changes in health care practices which would result in lowering the overall cost of health care. The respondents were asked if they would be very unwilling, somewhat unwilling, feel neutral about, be somewhat willing or very willing to make the six changes. Table Eleven summaries the results of the respondents willingness to make these changes. The ordering of items in Table Eleven is based upon the mean score for each item on a 1-to-5 scale were 1 is very unwilling, 2 is somewhat unwilling, 3 is neutral, 4 is somewhat willing and 5 is very willing.

Table Eleven shows that paying a higher co-payment, making fewer doctor visits, and waiting longer for non emergency appointments were rated higher than 3.0 (indicating neutrality) while accepting some limitation on choice of health care plans, accepting some limitations on access to the most sophisticated technology, and choosing physicians from a list provided by the insurer were rated less than 3.0.

TABLE ELEVEN
WILLINGNESS TO CHANGE HEALTH CARE PRACTICES
FOR COST CONTAINMENT

	Very Unwilling	Somewhat Unwilling	Neutral	Some Willing	Very Willing	N	Mean
Higher Co-payment	10.3%	8.0%	3.5%	56.8%	21.4%	398	3.71
Fewer Dr. Visits	12.3%	13.8%	9.3%	44.5%	20.3%	400	3.47
Longer for Appoint	18.0%	16.0%	3.3%	44.1%	18.5%	399	3.29
Limit on Plans	25.4%	20.2%	5.8%	41.8%	6.8%	397	2.84
Tech Limitations	27.6%	18.6%	6.8%	36.9%	10.1%	398	2.83
Choose Dr. Fr List	36.6%	18.3%	2.0%	35.0%	7.3%	399	2.59

The respondents were then asked how an increase in the deductible amount for their insurance would effect their use of health care services. Table Twelve shows that 23.2% of the respondents would use fewer services if their deductible was increased while 76.8% say their use of medical services would be unaffected.

Similarly, respondents were asked how a $5.00 to $10.00 increase in the amount of co-payment required for health care services would affect their use of the services. In the case of co-payment increase, 21.2% said they would use fewer services while 78.8% said their use of services would not be changed.

TABLE TWELVE
CHANGES IN MEDICAL PRACTICES IF

Deductible Increased

Use Fewer Services	90	23.2%
Use Same	298	76.8%

Co-Payment Increased

Use Fewer Services	83	21.2%
Use Same	309	78.8%

Finally, the respondents were asked to evaluate four health care plans. The respondents were asked to indicate if they were strongly opposed to, opposed to, had no opinion about, were in favor of, or were strongly in favor of each plan. The order in which these plans were presented to the respondents were randomized to prevent any bias which might be caused by the order in which the plans were described. Table Thirteen summarizes the respondents' evaluation of these four plans. The ordering of plans in Table Thirteen is based upon the mean score awarded each plan on a scale of 1-to -5 where 1 is strongly oppose, 2 is oppose, 3 is no opinion, 4 is favor and 5 is strongly favor.

TABLE THIRTEEN
EVALUATION OF PLANS

	Strongly Oppose	Oppose	No Opinion	Favor	Strongly Favor	N	Mean
No Coverage Required	5.5%	23.2%	9.9%	49.9%	11.5%	383	3.39
Individ Responsible	8.7%	34.4%	9.7%	40.4%	6.8%	381	3.02
Med Savings Account	22.5%	42.5%	9.1%	22.5%	3.4%	386	2.42
Canadian	34.7%	28.3%	8.2%	24.2%	4.6%	389	2.36

The plan receiving the most support from respondents was for a system similar to what we have now with additional regulation to control insurance practices. Under this system, coverage for all Montanans would not be required. The plan receiving the second highest level support was for a system similar to what we have now with additional regulation to control cost and expand health care coverage to all Montanans. Under this system, individuals would be responsible for obtaining and paying for their health care coverage. Each of these plans received a mean score greater than 3.0.

On the other hand, a plan calling for the establishment of a medical savings account and a plan described as the Canadian plan each received mean scores of less than 3.0.

SUMMARY

The 411 respondents interviewed in this survey were approximately half male and half female with a mean age of 46.5. The most common household type was a couple with children at home followed by a couple with grown children away from home. The most common employment status was working full time followed by being retired. Among those respondents who were working, the most common employer was the public sector followed by small businesses. For those respondents working in the private sector, the most common size of their employer was 6 to 25 employees followed by less than 5 employees although nearly one fifth said they worked for employers who employed over 100 employees.

The most common health insurance status was to have insurance partially paid by self and this was followed by insurance entirely paid for by self and then insurance entirely paid for by an employer. Respondents with health insurance coverage generally believed their coverage was good. About 15% of the respondents said that either they or a member of their household had been denied insurance because of health reasons. About 20% of the respondents who currently had insurance indicated that they or a member of their household had been without health insurance in the last three years. When this number is added to the respondents who indicated they currently had no insurance, a total of 26.2% of the respondents indicate that either they or someone in their household are currently without insurance or have been in the last three years. Eighteen percent of the respondents indicate they personally either are or have been without insurance in the last three years.

Slightly more than half the respondents said that either themselves or someone in their household had received emergency room care in the last three years while about 34% said either they or someone in their household had received outpatient surgery in the last three years and about 36% reported that either they or a member of their household had been hospitalized over night in the last three years. Nearly three-quarters of the respondent had a personal doctor. Fifteen percent of the respondents indicated that either they or someone in their household had received care from a chiropractor in the last three years while about 10% said either they or someone in their household had received care from a public health or school nurse in the last three years and about 3% said that either they or someone in their household had received care from a naturopathic doctor in the last 3 years.

Over fifty-four percent of the respondents thought the health care system was in need of either fundamental overhaul or major changes while 36% thought it was in need of minor changes. Only 9.2% thought no changes were necessary. When respondents were asked to evaluate the importance of a number of different goals of health care reform, the goal rated highest was to reduce waste followed by reducing cost increases, reducing the cost of prescription drugs, emphasizing preventive care, reducing the number of malpractice cases, providing universal coverage, providing coverage between jobs and improving the quality of health care. However, when asked what the single most important goal of health care reform was, the most common answer was to provide universal coverage.

The majority of the respondents felt the best designer of a health care system was a combination of the health care industry and state and federal government. A majority of the respondents also believed health care reform should be gradual instead of rapid.

Respondents generally liked the idea of limiting insurance premium increases, regulating hospital fees and doctor fees. Respondents felt more neutral about requiring coverage, making employers or individuals responsible for health care coverage, and requiring employers to pay more than employees for the employees health insurance.

Respondents generally liked the ideas that health insurance could not be canceled for any reason except lack of payment of premiums, that coverage would be guaranteed between jobs, that individuals could not be denied coverage because of pre-existing conditions and that employees could choose a plan from any offered in the state rather than accept the plan dictated by the employer.

More respondents felt that taxes would go up if health reform were enacted than if it were not. More respondents felt that health care costs would go up if health care reform were not enacted than if it were. More respondents felt that security of health care coverage would go up under health care reform than if no reform took place. More respondents felt that provider choice would go down if health care reform were enacted then if it were not. More respondents felt the quality of health care would go down if reform were undertaken than if it were not. More respondents felt that health care benefits would go up if reform took place than if it did not take place.

Nearly half the respondents believed that insurance companies had the most influence on the health care system. Respondents felt that hospital charges contributed the most to overall health care costs followed by insurance companies, malpractice suits, an aging population, administrative costs, new technology, doctor's fees, inappropriate use of the system, prescription drugs, long term care, lifestyle choices and increased violence in society.

Respondents generally believed that surgery, emergency care, preventative care, prescription drugs, abortion when mother's life is in danger, doctor visits, hospice care, dental care for children, medical rehabilitation services, abortion when pregnancy results from rape or incest, and mental health services should be included as benefits in a standard insurance policy available to all. There was some, but less support for physician assistant and nurse practitioner visits, for eye care, dental care, family planning services and substance abuse. There was a general belief that acupuncture care, general abortion services and naturopathic care should not be included. Abortion as a separately purchasable option was given a mean rating of 2.52 right at the dividing line between inclusion and exclusion.

Respondents indicated a general willingness to pay higher co-payments, go to the doctor less often, and wait longer for no emergency doctor appointments in order to decrease the overall cost of health care. Respondents indicated a general unwillingness to limit choices of health care plans, limit access to sophisticated technology and limit choices of a doctor to decrease overall health care costs.

About three-quarters of the respondents said their use of health care services would stay the same if their deductible amount were increased or if they had to pay $5 to $10 more as a co-payment for each visit.

Respondents generally favored a plan which would regulate insurance companies and not require health insurance coverage. They barely favored a plan in which individuals were made responsible for obtaining and paying for health care coverage and in which more regulation would occur to control cost and make coverage available to all. Respondents generally opposed a plan which relied on a medical savings account and a plan emulating the Canadian Health Care System.

SUMMARY

REGIONAL RESOURCE MANAGEMENT PLAN HEARINGS

September, 1994

SUMMARY
REGIONAL RESOURCE MANAGEMENT PLAN HEARINGS

TABLE OF CONTENTS

The Regional Planning Boards

The 53rd Montana Legislature in 1993 created the Montana Health Care Authority when it enacted Senate Bill 285 and directed the authority to establish five health care planning regions and boards.

Regional planning boards are authorized to engage in a variety of health reform activities, including advising the authority, public education, and facilitating public involvement. The boards are required by statue to fulfill nine duties, eight of which are largely procedural (see Planning Board Duties and Responsibilities, below). One, however, requires boards to:

> "...develop regional health resource plans in the format determined by the authority that must address the health care needs of the region and address the development of health care services in underserved areas of the region and other matters (50-4-402 (1)(d), MCA)."

The law also requires the regional board to "hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional board." Also, the law also requires the board to revise the regional plan annually.

Planning Board Duties and Responsibilities

The law (50-4-402 MCA) requires board to perform specific duties while other activities are authorized as activities in which they may engage.

(1) A board shall:

> (a) meet at the time and place designated by the presiding officer, but not less than quarterly;
>
> (b) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;
>
> (c) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines necessary;
>
> (d) develop regional health resource plans in the format determined by the authority that must address the health care needs of the region and address the development of health care services in underserved areas of the region and other matters;
>
> (e) revise the regional plan annually;

(f) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional board;

(g) transmit the regional plan to the authority at the time determined by the authority;

(h) apply to the authority for grant funds for operation of the regional board and account, in the manner specified by the authority, for grant funds provided by the authority; and

(I) seek from public and private sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

(a) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(b) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(c) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(d) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(3) Each regional board may review and advise the authority on regional technical matters relating to the statewide universal access plans, the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and facility contracts with the state, utilization review recommendations, expenditure targets, uniform health care benefits and the impact of the benefits upon the provision of quality health care within the region.

The First Regional Plans

Summaries of the first regional plans were developed through the spring and summer of 1994. They have been utilized by the authority in the preparation of a statewide resource management plan and are being used by regional boards to identify health care needs and solutions for their areas.

The regional plan contains substantial amounts of information, including social and demographic data, indicators of health status, and listings of health care resources. The plan follows closely the format prescribed by the authority and used in the preparation of a state resource management plan. Regional boards and others will now have the opportunity to evaluate the accuracy and usefulness of this information and recommend changes prior to revising the plan next year.

Valuable lessons gained from this effort will be especially useful to the authority in the preparation of a universal data base. In many instances, regional plans have been troubled by inconsistent or incomplete information, numerous sources of information, or the use of information never meant for planning purposes. A centralized base of health care data will obviate many of these shortcomings by providing a single coordinated and comprehensive source of information that will expedite the preparation of future regional plans.

The Regional Plan Hearings

The format for the regional hearings was devised in late July, with the emphasis on maximizing public exposure to the regional plans and public comment on them. However, given the rather technical and necessarily data-oriented focus of the regional plans, and the public's attention on 1) federal health care reform plans, and 2) state level development of the two universal access plans under SB 285, it was anticipated that public participation in regional plan hearings for this first plan would be low, and that the regional plans would gain prominence and attention when being updated in future years.

The simple format consisted of the regional chair calling the hearing to order, and turning the chair over to the hearings officer. The hearings officer would ask each member of the board to introduce themselves, and then ask the regional board consultant for the region to give an overview of the regional plan. The floor was then open for comments and questions from the members of the regional board, and the majority of the scheduled time of the hearing was set aside for questions and comments from the public.

As for the response to the public hearings, there are no common themes and no common environments. Hearings drew from five to sixty attendees. Some questions focused on the veracity of numbers used in the statistical section. Some questions focused on the data used: why some variables were used, and others were not. Some questions focused on the assessments, and

how solutions were determined. Other comments focused on the desire for different goals to be pursued.

Overall, however, it is possible to note an underlying consensus that the regional resource management plan and the regional planning boards are reasonable and valuable tools to help Montanans gain better control over their health care system.

The minutes of each regional hearing are appended to this brief report.

MINUTES
PUBLIC HEARING
on the
Draft Regional Health Care Resource Management Plan

Region I Health Care Planning Board
Monday, August 1, 1994
Community Room, Dawson Community College
Glendive, Montana

The hearing was called to order by the Chair, Paul Hanson, at 10:10 am. The following board members were also present: Merle Fitz, Nancy Hansen, Edward Gaub, Greg Cavanaugh, Sally Van Hemelryk, Mike Kennedy and Mike Quade. Also in attendance were six observer/participants.

The Chair introduced Sam Hubbard, Executive Director of the Montana Health Care Authority, who would preside as chairman for the public hearing on the Region III draft health care resource management plan. Board members introduced themselves, and Steve Yeakel, consultant to the board, was asked to present a brief overview of the draft plan.

Numerous constructive comments on the plan were offered, both by board members and members of the public.

Several questions arose regarding Health Professional Shortage Areas (HPSAs).

A question was asked regarding death rates, i.e. how rates could be determined for populations under 100,000.

A plea was made for the inclusion of any available Indian Health Service data. The consultant was pleased to report that IHS data had been obtained and would be appended to the appropriate regional plans.

Following a brief discussion regarding the difficulty of obtaining data, a question was asked about the validity of information collected. Assurances were given that, despite the challenges, the information that was finally obtained was as credible as possible, given the sources and current uses of the data.

One commenter asked about the interplay between state plans and federal reform plans, and inquired about the existence of any federal database(s). He also expressed his appreciation to all those with a hand in creating the regional plans.

Board member Merle Fitz discovered and reported a typographical error, emphasized the problems with timeliness and human error in reporting statistics and resource lists. He was most concerned about population counts, as they translate into federal dollars, through reimbursement formulas and other mechanisms, and asked about how timely changes in population are recorded.

While the record was held open, the formal hearing process was brought to a close at 10:55. No later comments were offered.

MINUTES
REGION II PUBLIC HEARING ON
DRAFT
REGIONAL MANAGEMENT PLAN
MONDAY, JULY 18, 1994
Have High School Auditorium
909 18th Street - Havre, MT 59501

Hearing officer, Sam Hubbard opened the hearing by giving an overview of the hearing procedures. He asked that comments focus on the information contained in the Region II draft regional management plan. The draft plan has been designed to identify healthcare resources, gaps and duplications. The hearing is held to give the public an opportunity to express concerns and make recommendations.

The hearing was opened and comment requested from members of the board and the audience. There was no comment and the hearing was closed. As soon as the hearing was closed, Montana Senator Greg Jergenson stated that the reason there was no comment was the fact that the information was received just a few days prior to the hearing and, for the most part, most of the audience had not seen a copy until they arrived at the hearing. Based on his comment, the hearing was reopened. Hearing officer Sam Hubbard asked Consultant Carole Erickson to give a detailed review of the plan, and comments were received from the board of directors and the audience.

COMMENTS

Some members of the audience had not attended the board meeting earlier. A request was made for the counties and representatives to be introduced.

Dave Sinclair - stated in Hill county, 6% is written off to underinsured or uninsured. He
inquired about pre-existing conditions and stated he felt the need for a unified data base should be listed as a priority.

Pat Suell, Big Sandy (physician's wife) commented as follows:

There are no pharmacists in Big Sandy

Physician recruitment - Physicians from metropolitan areas find rural Montana enticing due to the quality of life and people in the community. She feels the attitude from the medical board needs to focus on the positive qualities that are offered in Montana.

Administrator, Northern Montana Hospital - Inquired why the inventory list was compiled and management plan designed before we have addressed how it is going to be paid. Mr. Hubbard responded that the Health Care Authority did not have a hand in debating the legislation. The Health Care Authority's purpose is to move along in a parallel fashion to identify resource availability. Redistribution of resources and resource availability will continue to be evaluated.

Board member, Virginia Wooley stated that needs vary from region to region. When all 5 regions are evaluated, for the most part, region II counties have provided adequate care. With planning and forethought, we can take pride in what region II has to offer.

Board member, James Kelley indicated his major concern is the state adopting a single payer plan. With regard to the resource management plan, member Kelley wants assurance that we will not only collect data and perform analysis, but make decisions on addressing access problems, look at MAF assistance, organize purchasing pools to make an effort to provide services to underserved areas. Discussion followed regarding health care premium dollars and need for protection to provide assistance to areas that need them. Discussion ensued regarding the need to provide subsidies.

Dick Schaffer - Stated the market is not working because of government. He feels medicare should pay "full tilt" on the medicare program. There is too much free wheeling on malpractice. There should be caps placed on settlements. Hearing officer, Sam Hubbard commented that SB 285 mandates a Tort reform plan. Regarding medicare, the state has no control over the federal medicare program.

Nora Nelson - Hill County Commissioner - How will self insureds fare? Mr. Hubbard commented they cannot be included in the universal access plan unless an ERISA waiver is implemented.

Pat Suell - Commented on members of legislature. Ten years from now the same people will not be in legislature - example: look at the school system.

Mrs. Vizza - widow of a physician commented on the vast changes that have taken place in medicine. Office calls were $3.00, House calls - $5.00. It is now rare to find a physician who will make house calls. It is her opinion that medicine has not changed for the better with the implementation of Medicare and Medicaid.

Dick Schaffer stated that senior citizens deserve what they have from Medicare because it was promised to them.

Bruce Wagner commented on the fact that B/C-B/S is working closely with the State plan. State workers have received increased premiums with no increase in pay.

Don Holmquist - spoke as a small business entrepreneur and expressed concerns regarding healthcare reform and its impact on small businesses. He was unable to attend the board meeting and asked questions regarding the Universal access plans. Mr. Hubbard responded.

Senator Jergenson commented that healthcare issues have been building for years. Due to the fact there are scarce public resources, the needs assessment can assist to know how these resources should be spent. Portability and pre-existing diseases will be addressed as well as small groups from 3-25 to guarantee health coverage.

Hearing adjourned at 9:00pm.

MINUTES
PUBLIC HEARING
on the
Draft Regional Health Care Resource Management Plan

Region III Health Care Planning Board
Thursday, August 11, 1994
First Floor Conference Room, Transwestern III Building
Billings, Montana

The hearing was called to order by the Chair, Donna Wald, at 9:02 am. The following board members were also present: Carla Prinkki, Steven Berberet, Harry Felton, Anne Arthur, Mela Mlekush, Rick Larson, Ferne Prather and Brent Cromley. Also in attendance were approximately 45 observers.

The Chair introduced Sam Hubbard, Executive Director of the Montana Health Care Authority, who would preside as chairman for the public hearing on the Region III draft health care resource management plan. Board members introduced themselves, and Steve Yeakel, consultant to the board, was asked to present a brief overview of the draft plan.

Numerous constructive comments were offered. Some commenters offered their names, some did not. A list of the broadly focused comments and any possible immediate replies follows.

1. How will the health care services and costs for local (county) inmates be covered under any statewide health care reform scheme?

Reply: Not certain at this point. Will monitor as a part of the regional planning process, but more a part of the statewide plan development process.

2. A representative of the hospice association asked for validation of the numbers of hospices listed in the plan. Later, a similar question was asked by a naturopath.

Reply: All info re: services provided comes from Department of Health records. All information on persons licensed to perform a function were obtained through the Department of Commerce's Professional Occupation Licensing Bureau, except for the list of physicians and their specialties, which was provided by the Montana Medical Association.

3. One commenter asked that we focus on the numbers of *users* of services, as opposed to providers.

Reply: That might be a very good place to focus, but resources only allow us to reach this level at this time. Will include this point in critique of process.

4. One provider professional inquired about the source of the data used to determine per capita income figures, citing different ones for Yellowstone and the region. Others agreed, including a board member. They expressed a desire for the figure to be higher.

Reply: Figures were taken from the 1990 census. Other sources also provide estimates, and those estimates may be newer, higher. It may be possible to change the source for future plans, but the change would be made statewide.

5. Are waiting lists for services considered?

Reply: Just as users are not being counted at this time, neither are potential users.

6. How are services for family practitioners who are also providing OB/GYN care accounted for?

Reply: To avoid double-counting, physicians were only counted within the first specialty they listed on their licensing form. This comment raises a good issue, however, and the issue should be addressed as the planning process progresses.

While the record was held open, the formal hearing process was brought to a close at 9:55. No later comments were offered.

DRAFT

Minutes
Region IV Health Care Planning Board
Anaconda
August 10, 1994 12:00-4:00

Milly Gutkoski called the meeting to order at 12:10 and introduced Sam Hubbard, MHCA Executive Director who will also serve as the hearings officer for the public hearing portion of the meeting.

Sam declared the public hearing open and asked Bob Buzzas, consultant to Region IV, to summarize the regional resource management plan. Bob talked about the difference between the state resource plan, the state universal access plans and the regional resource plans and explained that the focus of today's hearing today is the regional resource management plan. A summary document was introduced as a condensed version of the approximately 100 page regional resource management plan which is still undergoing refinement and data verification.

Rather than producing a "plan," in the true sense of the word, the regional planning boards have had to focus first on gathering essential county and regional health care information which has never been assembled before. The first "plan," therefore, is primarily an inventory that is needed before any formulation of an actual "plan" is possible.

Bob reviewed the data categories in the summary and briefly highlighted some of the more characteristic data of the region. Several questions from the audience were referred to Sam Hubbard as they pertained to the state's universal access plans.

Sam then invited public comment; seeing none from the audience, he then asked for comments from the regional planning board.

Audrey Aspholm thought it was still important to include a needs statement concerning cost and finance and talked about its relevance to mental health service delivery.

A discussion on mental health services ensued including organic and emotional mental health issues. Audrey discussed the issue of organically brain damaged patients not receiving assistance because of a distinction being made between organic and emotional causes of mental illness.

Pat Antonick reported that she attended a meeting of the mental health region and informed the board that the state is drafting a mental health services plan for next year. The board expressed interest in learning more about the plan.

Sam reported that the Authority is modifying the mental health benefits in the multi-payer package to separate mental health from the outpatient maximum ($1000) for alcoholic and substance abuse. The Authority is striving to provide parity between

mental health and other health coverage and will use the same package of benefits as the Auditor's plan.

Bonnie Gebhardt raised the issue of professional shortages in light of a recent state inspection of the White Sulphur Springs hospital which was cited for not having a physician within 20 minutes at all times (they do have a PA). She wondered if this was a state interpretation of a federal regulation and if there was an agenda in state government to push small hospitals toward becoming MAF's. She pointed out that their hospital doesn't need more physicians just to fill this requirement, but the state seems to be forcing it in that direction.

Milly Gutkoski requested Bob Buzzas to get more information on the regulation and MAF's in general and report back at the next meeting.

Sam explained that developing a model integrated service network in rural areas is a # 1 priority of the Robert Johnson grant application and will be a part of the budget request in the next biennium. Regional boards would play an integral role in this area.

Barbara Egan suggested this should be included in the needs statement.

Jane Anderson of the Area V Agency on Aging said that she knows there is a need, but asked if the planning board or the Authority is coming up with any solutions? Sam explained that the legislature's intent was to first identify the needs and then work on the solutions. The required intermediate step is to take the state plans to the legislature.

After asking for and seeing no other comments on the regional plan, the public hearing was officially closed.

Milly resumed the chair and called the meeting to order. The roll was called and the following were present: Barbara Egan, Pat Antonick, Audrey Aspholm, Milly Gutkoski, Bill Parke, Terry Minow, Roy Nelson, Bonnie Gebhardt and Mary Sadaj. Absent were Ken Eden, Richard Brown and Bill Smith. Also in attendance were Sam Hubbard and Rae Childs of the Authority and Bob Buzzas from CIVIC Consulting.

The minutes of the last meeting were approved with corrections.

Representative Liz Smith was introduced. She thanked the board for the volunteer efforts and commended the work that both the board and the authority were doing.

The board decided to postpone the September meeting until October 6th, 2:00 PM, to be held at the Broadwater County Courthouse. Pat Antonick will invite the director of the Community Mental Health Center (Mental Health Services, Inc.) to address the board.

Sam reported on the last MHCA meeting. He pointed out that the data base needs (i.e. improving upon the quality of data for planning purposes) was added to the problem statement. Nutrition services are also being included as a part of in-patient hospital

care along with speech therapy. Mental health coverage is being separated from substance and alcohol abuse (capped at $1000) to be on parity with other health coverage.

Bonnie Gebhardt suggested that the board needed to address the needs statements. A discussion of the board's readiness to include statements on cost & finance and professional shortages followed. Some board members expressed concern with formulating a professional shortage statement at this point feeling more information was needed about shortages in each county of the region.

A motion was made by Bonnie to proceed with at least drafting possible statements in the areas of professional shortages and cost & finance for discussion at the October 6th meeting. The motion was seconded by Audrey. Motion was approved by voice vote. In consultation with Sam, it was determined that draft statements should be submitted to Bob Buzzas September 15th in order to be considered at the October 6th meeting.

A committee to draft a cost & finance statement was suggested to include Audrey, Barbara, Charlie and Bonnie. Bonnie also volunteered to try and draft a statement concerning professional shortages.

Barabara Egan discussed the importance of Certificate of Need and indicated an interest in receiving information.

Bill Parke said he was struck, in particular, by two statements made during the meeting regarding simpler, less costly alternative treatments that seem to get stopped by the established medical institutions in favor of more expensive methods.

Sam explained that any licensed primary care provider (including a naturopath ?) will be included under the state plans proposed by the Authority.

The meeting was adjourned by Milly and interested members of the board then toured the hospital facility in Anaconda.

PUBLIC HEARING
REGION V
REGIONAL HEALTH RESOURCE MANAGEMENT PLAN
DRAFT SUMMARY
AUGUST 4, 1994
VILLAGE RED LION - MISSOULA, MT

Hearing Officer: HCA executive director, Sam Hubbard
Recorder: Region V board member Myrna Chamberlin

Chairman Robin Swimley introduced members of the regional board, health care authority board member and staff, consultant. In addition, Chair Swimley gave a summary of the purpose of the regional health care planning board.

Hearing officer Hubbard set the ground rules for the public hearing as follows:

*limit comments to 3-5 minutes
*brief description of the plan
*open hearing for comments and interactive process
*identify name and organization represented
*written comments are welcomed

Consultant, Carole Erickson provided a brief overview of the plan focusing on:

*summary of region V priorities, reviewing changes made at 8/4 board meeting
*outlined long term planning process emphasizing that region V has completed the assessment aspect of the plan and the fact that developing a comprehensive plan will require a long term, evolving process.

The hearing was opened for comment. There were 75+ in attendance. Public comment and board response included the following:

Bob Scott - Hamilton

Attended the July regional meeting in Hamilton. Mr. Scott is concerned about lack of financial backing for both plans and feels we have put the cart before the horse by identifying resource plans without sufficient financial information.

Becka Robinson - Occupational therapist

Asked if O.T would be reimbursed under new plans and identified need for more OT's and better utilization within home settings since they are trained to practice in the home setting. Consultant reported 197 OT's in state--60 in Region V.

implement a public relation program to educate people on their services. Problem: Reimbursement.

Member Lulack:

The audience is filled with medical providers. Our first priority should be to promote ethic and capability for self responsibility. There is a need to focus on health issues in schools - along with promotion of sports.

Question: How do we get reimbursement for education? Member Newman states we currently have disease care providers rather than health care providers. How can we do it better? Legislator Brooke: Gathering data is going to be valuable information (ie, if we have data on pulmonary disease, will that data go into developing solutions toward prevention of pulmonary problems?). Member Leahy proposed that data look at health status not just financial and resource.

Teresa Henry - Community Health Nurse

We still need to have emergency, trained services as well as more opportunity for preventive inservices.

The hearing closed at 7:00pm.

STATEWIDE HEALTH RESOURCE MANAGEMENT PLAN

PUBLIC HEARING

September 22, 1994
Town House Inn
Butte, MT

STATEWIDE HEALTH RESOURCE MANAGEMENT PLAN

PUBLIC HEARING
September 22, 1994
Town House Inn
Butte, MT

Summary of responses from the Public Hearing for the Statewide Health Resource Management Plan:

Written comments were submitted prior to the public hearing which are attached. The first comment was received at the Authority's Helena office September 22, 1994, from Larry White, President of St. Patrick Hospital of Missoula. In general, Mr. White's comments reflect the need to clarify physicians services and to accurately reflect major medical equipment in the state.

Susan Adams, MS, RD, from Bozeman, provided written comment on behalf of the Montana Dietetic Association. Ms. Adams provided a definition for "nutritionists" which was developed by the MDA during a recent conference.

Ruth Haugland, Dillon, expressed her encouragement for the Authority to emphasize public health and primary care in the Plan. She indicated that she was much more comfortable knowing that the most recent version of the Plan included a chapter from the Department of Health & Environmental Sciences as required by law. She also requested that the Plan take into consideration the Public Health Improvement Plan developed by the Montana's Committee for Improving Public Health.

Suzy Holt, Director, Library Services, Shodair Hospital, Helena, testified that the Plan failed to take into account some distinctions in the area of information generation relative to health sciences and libraries section. She also provided some definitions, based on national standards, for health science libraries and librarians, and referred to a study developed by Governor Stephens' Task Force on Biomedical Information. In response to an earlier speaker, she suggested that hospital libraries are an integral component of the health delivery system by assisting health providers in their need to acquire relevant and valid information in a timely manner. She also provide the Authority with written comment from the National Network of Libraries of Medicine.

Richard Miller, Montana State Librarian, Helena, testified that professional hospital librarians can participate in the process of the provision of health care by providing information to the caregiver relative to specific questions on specific patient conditions. He also encouraged the use of the work produced by the Task Force on Biomedical Information in the Authority's deliberations on Resource Management.

Mona Jamison, Helena, recommended that the Authority adopt definitions for audiology and speech pathology in Chapter 7.

Executive Offices

St. Patrick Hospital

September 20, 1994 VIA FACSIMILE

Samuel T. Hubbard
Executive Director
Montana Health Care Authority
P.O. Box 200901
Helena, MT 59620-0901

Dear Mr. Hubbard:

I have reviewed the August 8, 1994 draft of the "1994 Montana Health Resource Management Plan", and would like to offer several observations. I also would like to commend your effort to develop a data base and analysis of the quantity and scope of health resources offered in Montana. The document provides useful information, and identifies a number of resource questions that should be considered within the context of health care reform.

My comments with regard to the data presented in the report are as follows:

(1) In determining the number of primary care physicians for Missoula County (Table III-2, page III-5), it appears that you have included in the "internal medicine" category those internal medicine physicians who practice a subspecialty such as cardiology or endocrinology. Though subspecialists may provide some primary care, it may only be a fraction of the services they provide. Thus, including them as full time primary care practitioners may overstate the number of primary care physicians in the county. Similarly, when looking at the number of physicians providing subspecialty care (Chapter VI), it seems important to recognize that many of these individuals may spend some portion of their time as internal medicine physicians providing primary care.

(2) Table XI-1 (Distribution of Hospital-Based Major Medical Equipment and Services by Region, page XI-4) fails to note that St. Patrick Hospital has both MRI and CT equipment. We also have available on a regularly scheduled basis a mobile Extracorporeal Shock Wave Lithotripsy unit. The Cancer Center at St. Patrick offers radiation treatment. Table XI-1 does not note our provision of these services.

Thank you for the opportunity to review the draft document.

Sincerely,

Lawrence W. White, Jr.
President

LLW/jmt

MONTANA HEALTH CARE AUTHORITY

Health Resource Management Plan

PUBLIC COMMENT FORM ON

HEALTH CARE REFORM

To be completed by interested individuals wishing to comment on the health care reform process being undertaken by the Montana Health Care Authority.

p. VII-3 Licensed Nutritionists provide medical nutrition therapy which involves: (a) assessment of the nutritional status of the patient or client, and (b) treatment, which includes diet therapy, counseling, or use of specialized nutrition supplements.

Submitted by: SUSAN ADAMS, MS, RD Date: 9/20/94
(Name)
MONTANA DIETETIC ASSOC.
(Organization, Address, Phone)
206 N. Grand W-586-8942
Bozeman, MT 59715

Please turn in your comments at Montana Health Care Authority meetings or Regional Health Care Planning Board meetings or mail your comments to Rae Childs at the Montana Health Care Authority or fax your comments to the Authority at 406/443-3417.

TO: Montana Health Care Authority

FROM: Montana Task Force on Biomedical Information

RE: Response to Montana Health Care Authority's draft *Statewide Health Care Resource Management Plan*

DATE: September 22, 1994

The Montana Task Force on Biomedical Information was appointed by former Governor Stan Stephens in February 1992 to:

> *"...assess the need for a designated coordinating agency, organization or institution with the responsibility for fostering the development of health information services statewide and to serve as the link between Montana's health care community and the National Library of Medicine's biomedical communications network."*

The Task Force presented its report to Governor Racicot in February 1993. As a result, health sciences libraries were included as a component of the health care delivery system to be inventoried and assessed in your resource management plan. Upon review of the draft of that plan, we have several concerns to bring to your attention.

Comments on the Management Plan

1. Chapter MCA 50-4-304 Section 8.2.b.vii specifies that the current supply and distribution of health science libraries and resources be identified.
    a. The heading for Chapter 12 needs to reflect that charge by including the term "Libraries".
    b. Health sciences libraries, their resources and services, are not the same as telemedicine or electronic bulletin boards and are not superseded by them. The distinctions among them need to be described so that they are understood by planners.

2. Pages II-1 and II-2 state that "the health care system in Montana should . . . (f) Facilitate universal access to health sciences information."
    a. Unfortunately, "information" is quite a nebulous term. The various types of information in health care, the purposes they serve and where they are found deserve description in Chapter 12.
    b. The most cost-effective, appropriate mechanism for delivery of each type of information requires analysis.

3. Page I-5 "Discussion" indicates that the Authority seeks standards to help measure adequacy of individual health resources and services.
    a) Nationally accepted definitions and standards exist for libraries in general, for hospital libraries, and for qualified librarians.

These need to be included in Chapter 12 and Montana resources measured against these commonly accepted standards; it is very misleading to indicate that Montana has 55 health sciences libraries.

i. We can supply the American Library Association and American Hospital Association definitions of a library, and the Medical Library Association standards for hospital libraries and "qualified librarians".

4. A variety of misperceptions and inaccuracies have slipped into the report and need clarification.

a. We can clarify what MEDLINE, Grateful Med, Loansome Doc, Docline, LaserCat are, what they are used for and by whom as well as help proof Chapter12 for other misperceptions.

Conclusions

The findings of the Task Force remain valid and its implementation plan outlined in its *Report to the Governor* provides an appropriate mechanism for accomplishing each of the recommendations stated on page10 of Chapter12 in your resource management plan..

You will recall that the Task Force was composed of a broad representation of authoritative Montana health care associations, providers, planners, educators and librarians. It makes good sense for the Authority to build on the work of that combined expertise and to endorse action on the implementation plan outlined by the Task Force.

Thank you for your attention to this unfamiliar, yet important, aspect of your charter.

For further information, please contact either:

Richard Miller, Montana State Librarian 444-3116
or
Suzy Holt, Director, Library Services, Shodair Hospital 444-7534

Steering Committee coordinators,
Montana Task Force for Biomedical Information

NN/LM
National Network of Libraries of Medicine
Pacific Northwest Region

University of Washington, SB-55
Seattle, Washington 98195
206-543-8262 / 800-338-7657
FAX: 206-543-2469
Internet: nalm@u.washington.edu

September 22, 1994

Suzy Hoit
Director, Library Services
Shodair Children's Hospital
840 Helena Avenue
Helena, Montana 59604

Dear Suzy,

Thank you for inviting us to review the "Health Sciences and Telemedicine" chapter of the draft 1994 Montana Health Resource Management Plan. Since the National Network of Libraries of Medicine, under contract to the National Library of Medicine, provided funding for the Montana Biomedical Information Task Force which led to the incorporation of provisions on library and information services in the state Health Care Authority legislation, we are particularly interested in the progress of this plan. We are also interested from the standpoint of our program mission, which is to ensure that all health professionals in the northwest have adequate access to health sciences information.

One of the hallmarks of our program is promoting the innovative application of information and communications technologies to support health professionals regardless of their location and geographic isolation. The northwestern US is relatively poor in terms of health sciences library and information resources. Technology can dramatically extend the reach of information resources and services, and often is the reason rural health professionals can remain where they are and continue to provide quality health care.

That being said, it is critical not to lose sight of the current reality and the limitations of promising technological delivery systems. Little of this promise can actually be realized without library collections and the skills of qualified librarians. In reviewing the draft Chapter Twelve: Health Sciences and Telemedicine, we are disturbed by a pervasive tone which implies that electronic systems have solved the problem of delivering information to health professionals. We wish that were the case, but it is not. The situation is not that simple nor does the spread and use of technology go that far.

Some points we would like to emphasize:

- Of the data on health sciences libraries presented in the chapter, by far the most significant is the number of hospital libraries with a librarian: 11. Eleven hospital

librarians to serve the hospital-based and affiliated health professionals in the state. Surely this is the most limited resource in the system.

- The state's health sciences libraries are effectively linked electronically and make use of a state-of-the-art electronic request routing system (DOCLINE). This enables librarians to communicate and process requests efficiently and to better meet the needs of their patrons/clients. But it does not work without them. A health professional cannot push a button and get an article. A librarian and a collection are still needed.

- GRATEFUL MED enables a health professional to search the literature from wherever he/she is. LOANSOME DOC further enables the receipt of documents as a result of such a search. These are tremendously beneficial innovations. Again, however, this ultimately doesn't work without a librarian and a collection to draw upon.

- The Virtual Medical Center is a brilliant communications system and resource for Montana health professionals. Our program has supported it in a number of ways and continues to do so. It has never been intended, nor has it been marketed, as a substitute for library services. It is an adjunct to such services. Through its "librarian on call" feature, it is one way to make the services of a librarian available to health professionals who would otherwise do without.

In summary, we support the recommendation for additional outreach programs to promote the use of computer-based library services among health professionals in Montana. This needs to be done. But, the fact remains that quality library service is not available without librarians and library collections, and these are limiting factors. Service can, and, in many cases, must be delivered electronically. But the services of a limited number of librarians can be stretched -- even electronically -- only so far. Resources and support for this end of the state system must be provided to ensure that health sciences library service in Montana does not break down.

Thank you, again, for the opportunity to comment on this draft. Please let me know if you have any questions or comments.

Sincerely,

Neil Rambo
Associate Director

cc: Sherrilynne Fuller, Ph.D., Director

Statewide Universal Health Care Access Plans

Public Hearings

Summary

September 21, 1994

Purpose

The Montana Health Care Authority conducted six public hearings to solicit public opinion regarding the content of the updated and revised draft of the single payer and multiple payer statewide universal access plans, as required by SB 285. This review of the testimony was prepared for the Authority board meeting in Butte on September 22 and 23, 1994, so that members would have the information for their consideration before the plans are finalized and submitted to the legislature and the Governor.

Public Hearing Schedule

Date	Place	Region
Wednesday, September 7, 1994	Missoula	Region V
Thursday, September 8, 1994	Bozeman	Region IV
Monday, September 12, 1994	Great Falls	Region II
Tuesday, September 13, 1994	Sidney	Region I
Wednesday, September 14, 1994	Billings	Region III
Tuesday, September 15, 1994	Helena	

The public hearings represent the final phase of citizen input. Over 82 public meetings have been held across the state during the existence of the Health Care Authority, enabling citizens to contribute at every stage of the process.

Participation

The public hearings were announced ten days in advance of each scheduled meeting and communicated to the Authority's extensive mailing list as well as through every form of public media: radio, television and newspaper. In addition, public hearing notices were printed in newspapers in Missoula, Bozeman, Great Falls, Sidney, Billings and Helena. Copies of the draft plans were mailed and circulated in advance and were available at the door of each hearing.

To encourage the broadest participation possible, all but one hearing was held from 7 pm to 10:00 pm, with sign-up for those wishing to testify from 6:30 pm to 7:00 pm. The hearing in Helena was held from 9 am to Noon. In Missoula 20 people testified, of 54 in attendance; in Bozeman 17 people testified, of 39 attending; in Sidney nine people testified, of 58 attending; in Great Falls 20 people testified, of 70 attending; in Billings 21 testifies, of 59 attending; in Helena 10 people testified, of 38 attending. Tape recordings were made of all testimony, with written testimony accepted both at the hearing and until 5:00 pm on September 20th at the office of the MHCA.

Review of Testimony

Almost all of the those in attendance favored some level of health care reform. Of the total of 330 in attendance, 97 testified. No individual addressed all of the issues in the health care proposals. Therefore, it is not possible to draw broad conclusions of public opinion from these collective data.

Only three people who testified said no changes in the health care system are necessary. The area of greatest support among those who testified was insurance reform. Most favor elimination of the waiting period for a pre-existing condition. Guaranteed issue and portability are also very important to a wide spectrum of testifiers. A large majority of those who testified want a Canadian-style single payer system without copayments, deductibles or any HMO type managed care component. Most of these individuals think that that the required copayments and deductibles are too high.

Many of those who testified want the benefit plan expanded to include home and alternate site coverage for respiratory care. Many also believe that Montanans require consumer education in such areas as comparisons of prices and success ratios of providers, how to maintain healthy lifestyle choices and how to deal with specific health issues such as diabetes. Several people requested an expansion of the mental health benefit to embrace parity with general health care.

A number of testifiers were concerned about how to finance reform. Several made suggestions. Of these, three wanted a sales tax, one wanted a one percent hike in the income tax and one suggested a $1.00 per hour increase in the minimum wage. Other areas that the Authority was encouraged to emphasize include managed care, reducing administrative overload and establishing a voluntary purchasing pool.

A few mentioned support for several other elements of the plans, such as the increased use of advanced practice nurses, improving the role of public health, streamlining medical administration by reducing the number and type of forms required for federal, state and private insurance reimbursement of medical providers, approval of universal coverage, immediate need for a long-term care plan, endorsement of the inclusion of nutrition services and a request for an increasing the allowable benefit for nutritional services.

Fewer mentioned support for medical savings accounts, tort reform, extending the scope of health care reform to include workers' compensation, a tax credit for self-employed individuals, inclusion of benefits for reproductive services,

expanding Medicaid to include all Montana children or the elimination of age bands in the proposal for modified community rating.

Six people who testified want the Health Care Authority to have a consumer representative without any of the professional designations of those individuals currently serving on the board. Five people asked that the members of the board refrain from making negative public statements about the plans, particularly the single payer plan.

Several people mentioned frustration with the format of the benefit plans. They want a format that would lend itself more easily to a side-by-side comparison of benefits between the single payer and multiple payer plans.

A handful of individuals pointed out the difficulty of getting ERISA exemptions from the federal government or any increases in the reimbursement rates for Medicare and Medicaid.

Comments

General

- widespread support in favor of a statewide data base, with particular concern that the information on fees, prices and outcomes be available to consumers
- significant concern over financing universal coverage under either plan
- universal coverage was identified as a serious goal
- significant support for reducing or eliminating waiting periods for pre-existing conditions, and other insurance reforms, i.e., guaranteed issue and portability
- cost containment approach too vague and ill focused
- frustration that benefit plans are too difficult to compare
- widespread support for a serious approach to consumer education
- supporters of both plans mentioned inadequate prescription drug coverage
- considerable support for home and alternate site care for respiratory care

Multiple Payer

- notable dislike of high cost sharing
- significant support for reducing or eliminating deductibles in favor of higher coinsurance
- very little support for individual mandates, concern that they will cause businesses to reduce their current participation in

employer-based coverage, also a general belief that they are not enforceable

- seniors are generally in favor of pure community rating
- subsidies received a great deal of comment, with no real concensus about how to finance or distribute them
- general interest in establishing voluntary purchasing co-operatives as cost containment measures
- great support for the preventive care emphasis of the plans
- numerous comments from ancillary services like respiratory therapists, mental health proponents, and nutrition counselors that still more emphasis is necessary on preventive care to avoid more costly acute care

Single Payer

- considerable opposition to the managed care option
- considerable opposition to cost sharing in favor of a constant, small copayment
- widespread support for the comprehensive benefit package
- general belief that cost estimates are too high, distrust of actuarial data

Newsletters

Health Reform UPDATE

Montana Health Care Authority

June 1994

Authority Board Drafts Two Plans

The Montana Health Care Authority outlined the basic features of two alternative benefit plans at its June meeting in Bozeman. The next step, a preliminary draft plan including a financial analysis, will be ready for the next Authority meeting in July.

A central issue, which shapes both plans, is that all Montanans should be required to have health insurance coverage. The Authority recommends that individuals be responsible for securing health insurance, with employers required to provide access to health care insurance through the work place. Employers would have no requirement to pay for coverage, but would continue to receive tax advantages for doing so. Insurance reform would provide consumer benefits such as portability, guaranteed renewal and elimination of exclusions for pre-existing conditions.

The basic benefits package for the regulated multiple payer approach would have low premiums and include preventive services which would be offered with no deductible or copayment. Other covered services, however, would have high deductibles and copayments. People who are already insured would probably be able to keep that coverage. Low-income people would receive state subsidies to help pay premiums. The exact cost of the subsidies is yet to be determined, but is estimated at $88 million per year. Eligibility for subsidies is to determined by income.

The single payer plan would require higher taxes instead of payment of premiums, but taxes might have to double to support such a system. Every Montanan would be covered by a generous insurance policy modeled on the Clinton administration plan. Cost estimates range upwards of $800 million per year.

The Authority also recommended a shift to a modified community rating approach so that rather than previous illness, age would be the only measure that insurers could use to vary the cost of insurance.

People would have to live in Montana three months before being required to purchase health insurance or be eligible for subsidies. Those covered by military insurance, veterans, Medicare, Medicaid or the Indian Health Service would be considered already covered and would not be eligible for a subsidy.

The Authority will now fill in the details and complete a financial analysis of each of the two plans. The draft plans will be circulated to interested parties, including local libraries and county courthouses. Town Meetings to discuss details of the two plans will take place in July and August. After consideration and possible modification as a result of this input, public hearings will be held in early September. The recommendations of the Authority will then be sent to Legislators to meet the October 1st deadline.

If the concensus of the Authority Board, after Legislative input, is that neither of the two alternatives is viable, a third alternative may be prepared. A strong possibility exists that an incremental approach to reform would be more affordable than either of the alternatives included in SB285.

Regional Developments

The Regional Health Care Resource Management Plans are nearly complete and will be available for discussion at Regional Public Hearings in July and early August.

The plans are will provide the data that will determine the distribution of future health care resources for Montana. The information is especially critical for the equitable distribution of services to underserved areas.

The plans will identify the current supply and allocation of hospital, nursing home and other inpatient services, home health and mental health services, treatment service for alcohol and drug abuse, emergency care, ambulatory care services, including primary care resources, nutrition benefits, prenatal benefits and maternity care, human resources, health sciences library resources and services, major medical equipment and health screening and early intervention services.

Equally important, the plan will set forth a statement of principles to be used in the allocation of resources and to establish priorities for future health services.

Finally, the plans will help determine the appropriate supply and distribution of resources and services.

The public hearing schedule is listed in a separate document available from the MHCA

News ...

Washington

Governor Mike Lowry signed a bill incorporating seasonal workers into the Washington Health Services Act of 1993. Next stages of implementation:

- employer mandates will be phased in between '95 and '97
- all residents must be insured by '99 under the universal coverage provision
- the Health Care Authority will become the health insurance purchaser for state-employed teachers 7/1/95.

Minnesota

A bill to implement the third phase of MinnesotaCare, establishing Integrated Service Networks (ISNs) is now in the legislature. If all goes as planned:

- Networks will be operational for all residents by '97
- insurance rate increases will be limited for small business
- the Health Financing Authority is responsible for preparing a plan to look at the feasibility of pooling state employees, Medicaid recipients, public school teachers, local government employees and an unknown number of people who are uninsured.

Arizona

Medical savings accounts will take effect in January 1995. Residents will be able to deposit $2000 per year into the tax-free account, with an additional $1000 available for each dependent, up to a maximum of $4000 per family. Unlike the proposed federal law, money left in the account is fully refundable, although it loses its tax-exempt status. No details are available as to how the state is funding the tax exemptions. The bill does not address workers whose companies don't provide insurance.

Kentucky

After two years of effort, Governor Brereton Jones signed the state's health reform legislation into law. It was pronounced dead many times and falls short of universal coverage, but the new law includes the following features:

- creates a 5 member Health Policy Board
- eliminates exclusions for pre-existing conditions
- requires providers to post fees and not change them
- limits self-referral by providers
- establishes a health purchasing alliance by 1995 that state employees and "possibly" Medicaid recipients will be required to join
- other public workers join by '96 or as existing contracts allow
- individuals or businesses with fewer than 100 employees can join voluntarily
- enacts insurance reforms such as portability, modified community rating and renewability
- enacts Medicaid reform

Williams Proposal Would Assist Rural Health Care

Representative Pat Williams' health care reform bill before the House Subcommittee on Labor-Management Relations would provide much needed assistance to rural health care in Montana.

The proposal would provide $100 million per year from 1996 to 1998, to be divided between hospitals and outpatient facilities in Medically Underserved Areas and Health Professional Shortage Areas. There are 41 Montana counties which have either whole or partial HPSA designations, of which 28 are either whole or partial MUAs. There are 25 Montana hospitals and 5 Medical Assistance Facilities which could receive funding.

Another $100 million per year between 1996 and 1998 would be provided in matching funds to rural areas for Emergency Medical Sevices.

Six Montana counties qualify as areas with more than 20% of the population below the poverty line. They include Big Horn, Blaine, Carter, Golden Valley, Petroleum and Roosevelt.

Training of rural health professionals other than physicians is the focus of $50 million per year in grant funds from 1996 to 2000, to encourage a substantial number of these graduates to provide health services in rural areas. Montana has degree programs in the following disciplines: 3 nursing programs, 4 medical technology programs, 1 medical records program, 1 physical therapy program and 1 occupational therapy program.

WINSM, a rural health care consortium formed by the seven universities located in Wyoming, Idaho, South Dakota, North Dakota and Montana has requested funds to provide enhanced training and access in these areas.

Four Types Analyzed ...

The final plan is a combination of two systems created by Montana special interest groups: the Tripart Plan, by Kirk Wilson, the Administrator of Great Falls Deaconess Hospital and the medical savings account proposed by Project '94. This combined system is expected to be the most difficult to cost from an actuarial standpoint, as there are no plans currently in operation from which to draw statistical comparative data. Both rely on a combination of 100% coverage for preventive services and catastrophic costs, with insurance coverage for all other costs.

Health Reform Update is published by the Montana Health Care Authority, Sam Hubbard, Executive Director. Questions should be addressed to Rae Childs, 28 N. Last Chance Gulch, Helena, MT 59601. 800-733-8208 or 406-443-3390.

2500 copies of this document were published at an estimated cost of $.10 per copy, for a total cost of $269.00.

Montana Health Care Authority Meetings

Date	Site	Focus
May 12-13, 1994 8 am - 5 pm	Old Supreme Court Chamber, Capitol Helena, Montana	Cost containment Service Delivery Single Payer Evaluation
June 9-10, 1994 8 am - 5 pm	Willson School Aud. 404 West Main Bozeman, Montana	Draft of Universal Access Plans Benefit Plans Cost Benefit Analysis
July 28-29, 1994 8 am - 5 pm	Park Place Auditorium 20 North 8th Street Miles City	Universal Access Plans Benefit Plans Cost Benefit Analysis
August 15-16, 1994 8 am - 5 pm	Park Inn Mountain Room 211 East Main Lewistown, Montana	Certificate of Need Study Defensive Medicine Benefit Plans
September 15-16, 1994 8 am - 5 pm	War Bonnet Inn 2100 Cornell Avenue Butte, Montana	Finalize Universal Access Plans Benefit Plans Cost Containment Plan
October 20-21, 1994 8 am - 5 pm	Grouse Mountain Lodge 1205 Highway 93 West Whitefish, Montana	Consideration of Legislative Response

Opportunities for Public Input

The Montana Health Care Authority was established in 1993 to pursue comprehensive health care reform in Montana. The Authority must submit two alternative health care financing proposals to the 1995 Legislature. One will be a single payer plan and the other a regulated multiple payer plan. Between now and September 15, the board of the Authority will be collecting health care facts, listening to citizen input and analyzing cost and benefit data. To date they have met in Billings, Missoula, Great Falls, Helena and Sidney. Future meetings will take place in Bozeman, Butte, Whitefish, Lewistown and Miles City. There is ample time provided at each meeting for public input.

Special Accommodations

The Montana Health Care Authority will make reasonable special accommodations for persons with disabilities who wish to participate in our public meetings. To request an accommodation, please contact Elinor Edmunds at 406-443-3390 or 800-733-8208 or Fax 406-443-3417.

Regional Health Care Management Plans

There are regular meetings of the Regional Health Planning Boards held in many towns across the state. The regional planning boards are charged with preparing a regional health care resource management plan, which is an inventory of all the health care resources in the state. This plan will list the details of the resources we currently have, and thereby expose the gaps. Regional board members are gathering information on a county-by-county basis and are meeting with residents as well as officials of all localities in Montana. These meetings may come to a town and at a time that is more convenient than an Authority Board meeting. There is time set aside at each regional meeting for Montana residents to comment on the resource plans. Future meeting sites include Glasgow, Great Falls, Chester, Billings, Dillon and Kalispell.

This is a publication of the Montana Health Care Authority, Sam Hubbard, Executive Director. Questions may be addressed to Rae Childs, 28 N. Last Chance Gulch, Helena, MT 59601. 800-733-8208, 406-443-3390 or Fax 406-443-3417. 2500 copies were printed at a cost of $.10 per copy, total cost of $269.00.

Regional Health Care Planning Board Meetings

Region 1:	Monday , May 16, 10 am - 2 pm Cottonwood Inn, Banquet Room U.S. Highway 2 East Glasgow, Montana
Region 2:	Tuesday, May 18, 1994, 10 am - 2 pm Civic Center, Missouri Room Park Drive at Central Avenue Great Falls, Montana
	Public Hearing on Region II Health Resources Plan and Regional Planning Meeting Thursday, June 23, 1994, 5 pm - 9 pm Chester High School Auditorium School and Main Streets Chester, Montana
Region 3:	Thursday, May 19, 1994, 4 pm to 7 pm Student Union Building, Remington Room Eastern Montana College Billings, Montana
Region 4:	Thursday, May 19, 1994, 9 am to 7 pm Office Classroom Building, Room OC114 Western Montana College Dillon, Montana
Region 5:	Friday, May 20, 1994, 9 am to 1 pm Cavanaugh's, Ballroom A 20 North Main Kalispell, Montana

Citizen's Forums

Date

Monday, May 16
6:30 pm - 9:30 pm

Wednesday, May 18
6:30 pm - 9:30 pm

Thursday, May 19
6:30 pm - 9:30 pm

Site

Cottonwood Inn
Banquet Room
U.S. Highway 2 East
Glasgow, Montana

Civic Center
Missouri Room
Park Dr. & Central
Great Falls, Montana

Cavanaugh's
Ballroom A
20 North Main
Kalispell, Montana

Forums: Public Opinion Survey

Three citizens' forums will be held in May. This is an innovative process for gathering public opinion. Montana residents will be selected by random sample. The participants will discuss concerns, rank opinions and provide instant feedback on issues involved in health care reform. The responses from involved respondents will be compiled instantaneously during the meeting. Paper input forms will be available so that the general public can also take part.

Health Reform UPDATE

Montana Health Care Authority

April 15, 1994

Sidney Authority Board Meeting Confronts Details

The Montana Health Care Authority Board meeting in Sidney on April 13-14 began to sift through the complex details that must be mastered in order to create two alternative universal health care reform plans for Montana.

"The devil is in the details," Chair Dorothy Bradley reminded the group, "and it's time to confront them. Our legislation requires that each of our plans must include guaranteed access to health care services for all Montana residents, a uniform system of benefits, portability of benefits, mechanisms for reducing the cost of prescription drugs, appropriate use of midlevel practitioners, integration of benefits, to the extent possible, with those now provided by the Indian health service, medicare, medicaid and the Veterans Administration. All of this must be accomplished under a unified health care budget, with a system capped for provider expenditures, a binding cap on overall expenditures and incentives to be used to contain costs.

"We can easily construct tight controls that manage the budget for this sector of the economy. On the other hand, we can devise the flexible, encompassing benefit plan that will guarantee services to our residents. The difficulty is going to be making sure that the structure fits together when we are finished, in other words, that we have a rational, effective, affordable plan that will meet the goals of the statute and will improve the current situation."

"Our goal for this meeting is to have a discussion draft of the multi-payer benefit plan, followed by a discussion draft of the single-payer plan by our meeting in May in Helena," Bradley noted.

Uniform Benefit Package

Dr. Larry Bartlett, president of Health Systems Research, and lead consultant to the Authority, directed a discussion of the design of a uniform benefit package which concentrated on several key elements:

- comparison of selected health benefit packages including the latest version of the Clinton Administration's Health Security Act, the Vermont proposal, the Montana state employee health benefit program, the proposed standard benefit package developed as part of Montana's small group market reform, and several Blue Cross/Blue Shield products currently being sold in Montana's small group market;
- major design areas including benefits, limits or exclusions, cost sharing features such as deductibles, copayments, coinsurance and subsidized premiums; and
- the role of a uniform benefit package in establishing a benefit floor and in determining the levels of suitability of basic, mainstream or comprehensive coverage.

Cost Containment

The Authority is also required to focus attention on health care cost containment

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Electronic Citizens' Workshops Scheduled

The Montana Health Care Authority will use an innovative technology in three citizens workshops which will allow participants to discuss concerns, rank opinions and provide instant feedback on issues involved in health care reform.

"The workshops have been scheduled in Glasgow on May 16, Great Falls on May 18 and a third on May 19 at a site yet to be determined," according to Elinor Edmunds, Public Participation and Education Director "These workshops will function like a large focus group and we are very excited about this method of receiving representative citizen input."

The Electronic Group Interaction System (EGIS) is a portable computerized meeting system. Each meeting participant responds to material being presented using a hand held responder. Individual reactions are continuously recorded on the system computer. Results are projected for viewing by all participants. The data are saved and are then available for instant statistical analysis.

"The workshops audiences will be divided into two groups," Edmunds explained. "150 people selected by random sample from the voter registration lists will use the EGIS responders. The rest of the group will use paper input forms to take part in the workshop."

Edmunds pointed out that "this method of inviting participants was determined in order to assure a

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Montana Health Care Authority Meetings

Date	Site	Focus
April 13-14 8 am - 5 pm	Moose Hall Sidney, Montana	·Structuring Uniform Benefit Plans ·Regulated Multiple Payer Evaluation ·Comparison of covered benefits ·Cost sharing -analysis of advantages and limitations
May 12-13, 1994 8 am - 5 pm	Old Supreme Court Chamber, Capitol Helena, Montana	·Cost containment ·Service Delivery ·Single Payer Evaluation
June 9-10, 1994 8 am - 5 pm	Willson School Aud. Bozeman, Montana	·Discussion Draft of Universal Access Plans ·Cost Benefit Analysis

Electronic Citizens' Workshops

See related story for further information.

Date	Site
Monday, May 16, 1994 6:30 pm - 9:30 pm	Glasgow, Montana
Wednesday, May 18, 1994 6:30 pm - 9:30 pm	Great Falls, Montana
Thursday, May 19, 1994 6:30 pm - 9:30 pm	Site to be announced

Electronic Citizens' continued

representative cross section from which a valid public opinion sample can be assessed.

The EGIS system has been used to measure input by many other groups including the Bonneville Power Administration, the Public Broadcasting System, the United States Forest Service, and a Health Care Forum sponsored by U. S. Representative Maria Cantwell, WA.

1,200 copies of this public document were published at an estimated cost of $.15 per copy, for a total cost of $180.00, which includes $180 for printing and $.00 for distribution.

Details continued

strategies. In Montana between 1980 and 1990, when health care spending was estimated to have grown by 143%, total wages and salaries for workers increased by only 52%. If current trends continue, by the year 2000 health care spending in Montana will reach nearly $3.5 billion, or roughly $4,700 per person. "It's simple," Bradley pointed out, "without cost containment, there can be no affordable benefit plans."

The Authority will deal in depth with cost containment issues at its May meeting in Helena.

Sixty-six More Public Input Opportunities

April 15 - June 15
- 3 Authority Board Meetings
- 3 Electronic Citizens' Workshops*
- 12 Regional Planning Board Meetings
- 5 Public hearings on regional resource management plan
- 1 Telephone survey*

June 16 - September 16
- 4 Authority Board Meetings
- 10 Town Meetings on draft plan
- 5 Public hearings on draft uniform benefits plans held jointly with regional planning board meetings
- 10 Focus groups*

After October 1, depending on Robert Wood Johnson Grant
- 3-5 Citizens' workshops*
- 5 Regional board meetings
- 5 Authority board meetings
- 1 Telephone survey*

* Some or all of the individuals involved will be selected by computer-generated random sample to assure a representative cross-section.

Health Reform Update is published by the Montana Health Care Authority, Sam Hubbard, Executive Director. Questions should be addressed to Rae Childs, 28 N. Last Chance Gulch, Helena, MT 59601. 1-800-733-8208.

Montana
HealthCare
Authority

HealthCare REFORM

wsletter – March 1994

roblem atement rafted

The draft problem statement defining the need for health care reform in Montana was presented to the February Authority Board meeting and is now being considered by the Regional Health Care Planning Boards. Excerpted here, the full text is available through the Montana Health Care Authority office.

Whether or not we have a full-blown "crisis" on our hands, the facts demonstrate the existence of a multifaceted set of problems that exist within the health care system. These problems can be grouped into the areas of health care costs, insurance coverage, availability of care and health status.

• According to an analysis published by the Families USA Foundation, from 1980 to 1990, total health care spending in Montana increased from roughly $676 million to over $1.6 billion, an overall increase of 143%, which reflects an average annual growth rate of 9.3%. Per capita spending rose from $859 to $2,059 during that period.

• If current trends continue, by the year 2000, health care spending in Montana will reach nearly $3.5 billion, or roughly $4,700 per person.

• Between 1980 and 1990, when health care spending was estimated to have grown by 143%, total wages and salaries for Montana workers increased by only 52%.

• According to the Employee Benefits Research Institute, in 1970 health care benefits paid by corporations nationwide were equivalent in value to roughly 35% of their after-tax profits. By 1980, health benefit payments equalled about 48% of after-tax profits, while by 1989 they were roughly equal in value to after-tax profits.

• Montana's share of the costs of Medicaid is approaching 15.6% of the annual general fund budget, thereby severely reducing our ability to finance other badly needed services such as education, infrastructure development and public safety. In addition, the cost of the state employee health benefit coverage further adds to the portion of the state's general fund budget that is consumed by health care costs.

• Cost shifting results in individuals with private insurance coverage paying higher prices. Part of the reason that health care costs are increasing for businesses and individuals is the fact that hospitals and other health care providers are forced to raise their charges to persons who have private insurance in order to cover the cost of providing care to uninsured persons or make up for inadequate reimbursement from government programs.

• Nine of Montana's counties do not have a single physician.

• Half of all the hospitals in the state (with less than 30 beds) have suffered significant financial losses for at least eight consecutive years.

Regional Health Care Planning Boards

In late 1993 the Authority Board appointed regional board members from nominations provided by county commissioners in each county. Each county has a representative on the regional board in its geographic region. Regional board members include consumers, county welfare administrators, homemakers, hospital administrators, nurses, physicians, insurance agents, business people, senior citizens, local public health administrators, accountants, a physician assistant, an optometrist, a nutritionist, an attorney, and a city-county public health administrator.

On January 21, 1994 the five Regional Health Care Planning Boards held their inaugural meetings in Helena. Each regional board is primarily responsible for developing the regional health care resource management plan that addresses the health care needs of the region and the development of health care services in underserved areas of the region. The regional boards will also advise the Authority in developing the statewide resource management plan. To fulfill this and other roles, the regional boards will be heavily relied upon to facilitate public information and education, provide a regional and local perspective on the statewide resource plan, and to provide a communication conduit with consumers and providers at the local level.

During the next several months regional board members will be meeting with community leaders, health care providers, consumer groups, and others who are involved and interested in health care and health care reform. They will learn about the available resources, needs, and deficiencies in their region's health care services and how this relates to undeserved sectors. This information will be compiled into a draft regional health care resource plan. Each region will hold a public hearing on its draft plan. The schedule for the upcoming meetings of the regional planning boards and a list of each regional board's presiding officer are included in this newsletter. Public participation is encouraged and welcomed at all of the regional health care planning board meetings.

Information

The Montana Health Care Authority toll-free line is printed below, please let us know your questions, concerns and suggestions.

800-733-8208

Regional Planning Board Meetings

Meeting rooms will be announced as arrangements are made.

Region 1: **Monday, May 9, 1994,**
10:00 a.m.
Glendive, Montana*

Region 2: **Tuesday, March 22, 1994,**
9:00 a.m.
Blue Sky Villa, Conrad, Montana

Region 3: **Wednesday, April 20, 1994,**
9:30 a.m.
Billings, Montana*

Region 4: **Saturday, April 23, 1994,**
1:00 p.m. to 5:00 p.m.
Bozeman, Montana*
Thursday, May 19, 1994,
4:00 p.m. to 7:00 p.m.
Dillon, Montana*

Region 5: **Thursday, March 24, 1994,**
6:00 p.m. to 10:00 p.m.
Kalispell, Montana*

Presiding Officers for Regional Health Care Planning Boards

Region 1: **Paul Hanson**
1614 N. River
Glendive, Montana 59330
Work Phone: 365-3306
Home Phone: 365-6924

Region 2: **Jerome Morasko**
P.O. Box 915
Shelby, Montana 59474
Work Phone: 434-5536
Home Phone: 434-5746

Region 3: **Donna Wald**
Star Route
Lodge Grass, Montana 59050
Work Phone: 665-2310
Home Phone: 639-2457

Region 4: **Milly Gutkoski**
304 North 18th
Bozeman, Montana 59715
Work Phone: 587-3242
Home Phone: 587-3242

Region 5: **Robin C. Swimley**
P.O. Box 1510
Libby, Montana 59923
Work Phone: 293-2785
Home Phone: 293-3389
Fax: 293-6969

Montana Health Care Authority Staff

The staff of the Montana Health Care Authority provides day-to-day support for the comprehensive health care reform process now underway. The duties and responsibilities of each staff position are directly correlated to the tasks and deadlines established by SB 285.

Mike Craig is Planning and Research Director, Elinor Edmunds directs Community Education, Rae Childs is Communications Officer and Agnes Wismer is Administrative Assistant.

Craig was most recently Chief of the Department of Health and Environmental Sciences Licensure Bureau. Previously, he was Health Care Needs Analyst for the Health Planning Program at DHES. Mike has a B.A. in Political Science/Public Administration and an M.P.A. in Public Administration from the University of Montana.

Edmunds has been Research and Development Manager for the Montana Science and Technology Alliance for the past three years. She formerly served as an Investments Analyst and Administrative Officer for the Alliance. She holds a B.A. in Communication Arts and Sciences from Michigan State University.

Childs has been an advertising, public relations and marketing consultant for the past three years. Prior to that, she was an insurance agent, managed an advertising agency and was public information officer for the Department of Highways and the Office of Public Instruction. Childs studied Journalism at the University of Montana and Public Relations at UCLA.

Wismer has been the secretary for the Natural Resource Damage Program of the Environmental Sciences Division at the Department of Health and Environmental Sciences since 1991. She was the Administrative Aide in the Health Services Division at DHES, an administrative aide in the Research Office and the Physical Facilities at Montana College of Mineral Science and Technology, and Administrative secretary at the Bureau of Mines.

News Bites

Sixteen states are forging ahead with health care reform despite uncertainty about the outcome of President Clinton's proposal now before Congress. "States want a system established so they'll be ready in case any reform package passes," according to Tim Curley, health policy analyst at the National Governors' Association. "Spiraling costs are driving many states to enact laws because they cannot afford to wait and they know that if federal reform is passed they can get a waiver or be grandfathered," Curly said. "At the same time," he explained, "they will have a program that is designed for them rather than one designed for some other state over which they had no control." For more information on the activity in each of the sixteen states, contact the Montana Health Care Authority for a copy of the January **State Health Watch**.

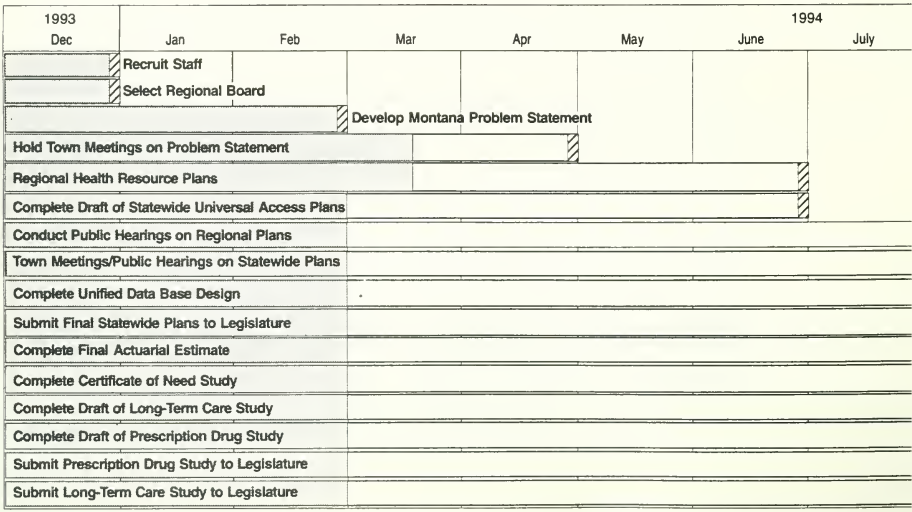
The news reports regarding **Oregon's** system of health service prioritization may be somewhat misleading. The fact is that the system of allocation in their law applies only to their Medicaid case load.

The **Washington** state plan, enacted in 1993, is very close to that of the Clinton Administration. Among other things, the Washington plan sets a minimum benefit package and requires all employers to pay 50% of the lowest premium in an area for their employees. Premium limits are set by the state.

Prioritization is mentioned twice in SB 285. First, the Authority is directed to include, in the cost containment component, a system for limiting demand for health care services that allows for consideration of an individual patient's prognosis. Second, the health resource management plan must include a statement of principles used in the allocation of resources and in establishing priorities for health services.

Authority Meeting Videos

Videotapes of the Authority Board Meeting are available for your convenience. They may be reserved by calling 800-733-8208 or 443-3390.



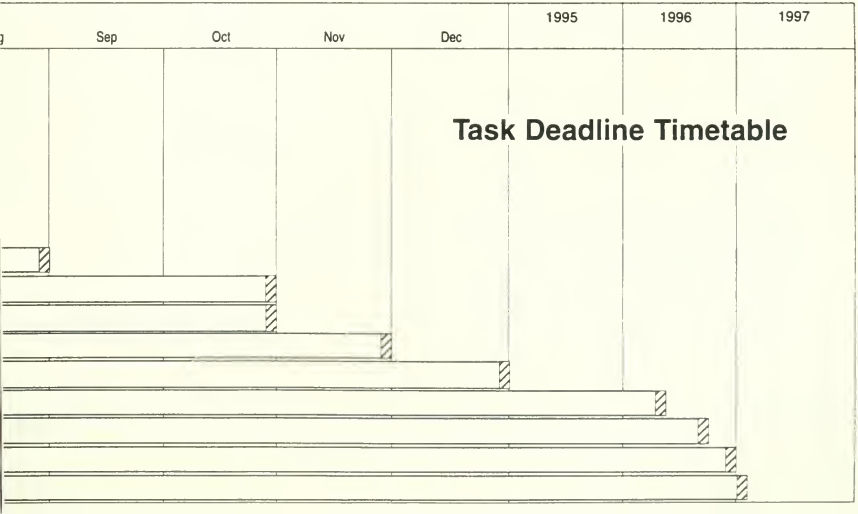
urchasing lliances

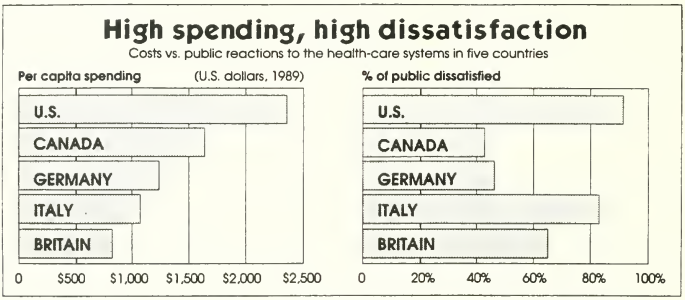
Health insurance purchasing alliances are central to many state and federal health care reform proposals. Quoted in **State Health Watch**, Elliott Wicks of the nonprofit Institute for Health Policy Solutions, Washington, D.C., considers such alliances as having the "potential to help solve a number of critical problems plaguing the health care system."

"Purchasing alliances or purchasing cooperatives would provide a practical way to deal with the problems of risk selection," Wicks said, "Even with community rating, there are too many ways for an insurance company to get away with selection of markets. These visible activities would be monitored by the alliances. Purchasing co-ops would also provide a wide selection of health benefit plans, usually between 10 and 15, that consumers could choose between. Currently," Wicks explained, "small business employers have a particularly hard time providing a wide array of choices. Another problem that alliances would solve is portability. An employee wouldn't have to change plans or providers when he changes employment."

As part of an in-depth guide for state policy makers, the Institute has identified eight states with recent laws that clearly include features of purchasing alliances, also known as health insurance purchasing cooperatives (HIPCs). They include **California, Florida, Iowa, Minnesota, North Carolina, Ohio, Texas and Washington**. The variations on this theme are very instructive. For more information or a copy of the **State Health Watch** contact Rae Childs at the Montana Health Care Authority 800-733-8208 or The Institute for Health Policy Solutions 202-857-0810.

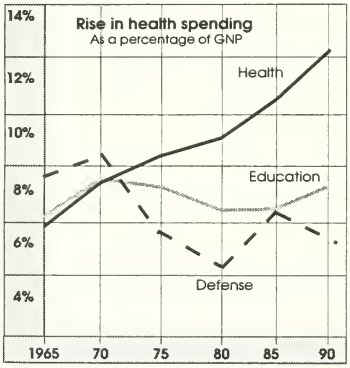
In a related article, the National Association of Insurance Commissioners is considering the "heart of the issue" according to the February 1994 newsletter **State Health Watch**. The NAIC believes the central question is "how much authority should HIPCs have to negotiate with health plans over price, quality and other vital issues." They are developing a model law to guide the states. They question whether participation in the purchasing co-ops should be voluntary or mandatory. According to the Clinton plan, the ability to negotiate rates is critical to the success of the purchasing co-ops. And in order to negotiate comprehensive rates, all insurers would have to be part of the process. Insurers are concerned that they could find themselves squeezed out of the market altogether.





Sources: Health Affairs, Summer 1990, Fall 1991; Harvard-Harris-ITF Ten Nation Survey, 1990; OECD Health Data 1991; The Logic of Health Care Reform, Paul Starr.

The U.S. ranks highest in both spending and dissatisfaction. Generally, low spending is directly related to high dissatisfaction. Except in the United States, which has the lowest approval while spending more than any other country.



Sources: HCFA, National Center for Education Statistics, Statisticol Abstract of the U.S.; The Logic of Health Care Reform, Paul Starr.

Today, the U.S. spends twice as much on health care as it does on education and defense combined. Yet, we do not have a healthier society than other Western countries that spend far less.

Montana's rate of growth in family spending on health care is 6th in the nation.

Sources: Families USA, HCFA Health Data

low many eople are ninsured in fontana?

Q&A

Statistics vary, depending upon the year, the time of year, employment and other factors which are constantly changing. The University of Montana Bureau of Business and Economic Statistics found about 16% of the adult population uninsured in August 1992, or at least 90,000 adults. In addition, these uninsured claimed an average of at least one dependent, many of whom are children. If all these dependents were also uninsured, the total could be closer to 180,000 uninsured people, or roughly 22% of the total population.

According to Medicaid figures computed near the same time, 140,000 Montana residents are uninsured, including 50,000 children.

From 12% to 16% of the state's population may be uninsured at a given point in time. This means that from 95,000 to 180,000 Montanans are without insurance. The fluctuation relates to such things as seasonal employment and gaps in employment. Both University of Montana and national studies show that the number of Montanans who lack health care coverage for an entire year is much smaller, while the total number of persons who are uninsured at any time over the course of a year is much higher.

The UM study also revealed that 47% of those surveyed had been through periods in their adult lives where they had no coverage for an average of five years. They discovered that 31% had periods within the last year without insurance. Which brings up the issue of gaps in coverage, with all the attendant problems of exclusions such as pre-existing conditions, new waiting periods and deductibles.

ontana ranks in the country e percentage amily income spend on alth care.

es: Families USA, HCFA Data

How America stacks up internationally

	Health spending* per capita	Inpatient days per capita	Physician contacts per capita	Infant mortality per 1,000 live births	Life expectancy (male) at birth	Life expectancy (male) at age 80	Percent of population age 65 and over
U.S.	$2,354	1.3	5.3	10.0	71.5	6.9	12.3%
CANADA	$1,683	2.0	6.6	7.2	73.0	6.9	11.1%
GERMANY	$1,232	3.5	11.5	7.6	71.8	6.1	15.4%
JAPAN	$1,035	4.1	12.9	4.8	75.5	6.9	11.2%
BRITAIN	$836	2.0	4.5	9.0	72.4	6.4	15.6%
OECD average for 24 nations	$1,059	2.8	6.0	10.6	72.1	6.3	13.0%

* In U.S. dollars, 1989

Sources: Health Affairs, Fall 1991; OECD Health Systems Facts and Trends and OECD Health Data, 1991; The Logic of Health Care Reform, Paul Starr

There appears to be an inverse proportion between the amount of money devoted to health care spending and the results of the health care that citizens receive.

Authority Board Meeting Schedule

Friday, March 18, 1994
8:00 a.m. to 5:00 p.m.
Old Supreme Court Chambers, Room 325
State Capitol Building
Helena, Montana

Wednesday, April 13, 1994 and Thursday, April 14, 1994,
8:00 a.m. to 5:00 p.m.
Moose Lodge
101 Third S.E.
Sidney, Montana

Thursday, May 12, and Friday, May 13, 1994
8:00 a.m. to 5:00 p.m. both days
Old Supreme Court Chambers, Room 325
State Capitol Building
Helena, Montana

Thursday, June 9, and Friday, June 10, 1994
8:00 a.m. to 5:00 p.m. both days
Location to be Determined
Bozeman, Montana

ACCOMMODATIONS

The Montana Health Care Authority will make reasonable accommodations for persons with disabilities who wish to participate in our public meetings. To request an accommodation, please contact Elinor Edmunds at 406-443-3390, or 800-733-8208 or FAX 406-443-3417 to advise us of the nature of the accommodation that you need.

5,000 copies of this public document were published at an estimated cost of 34¢ per copy, for a total cost of $1,700.00, which includes $1,700.00 for printing and $.00 for distribution.

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